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STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN MEDICAL JOURNAL

1903 - 1978 75th ANNIVERSARY YEAR

JANUARY 1978

• 75th anniversary of the Wisconsin Medical Journal • Family practitioners and surgical privilege • The practice of investigative internal medicine • The EMT-Paramedic in an emergency system • Council endorses uniform claim form

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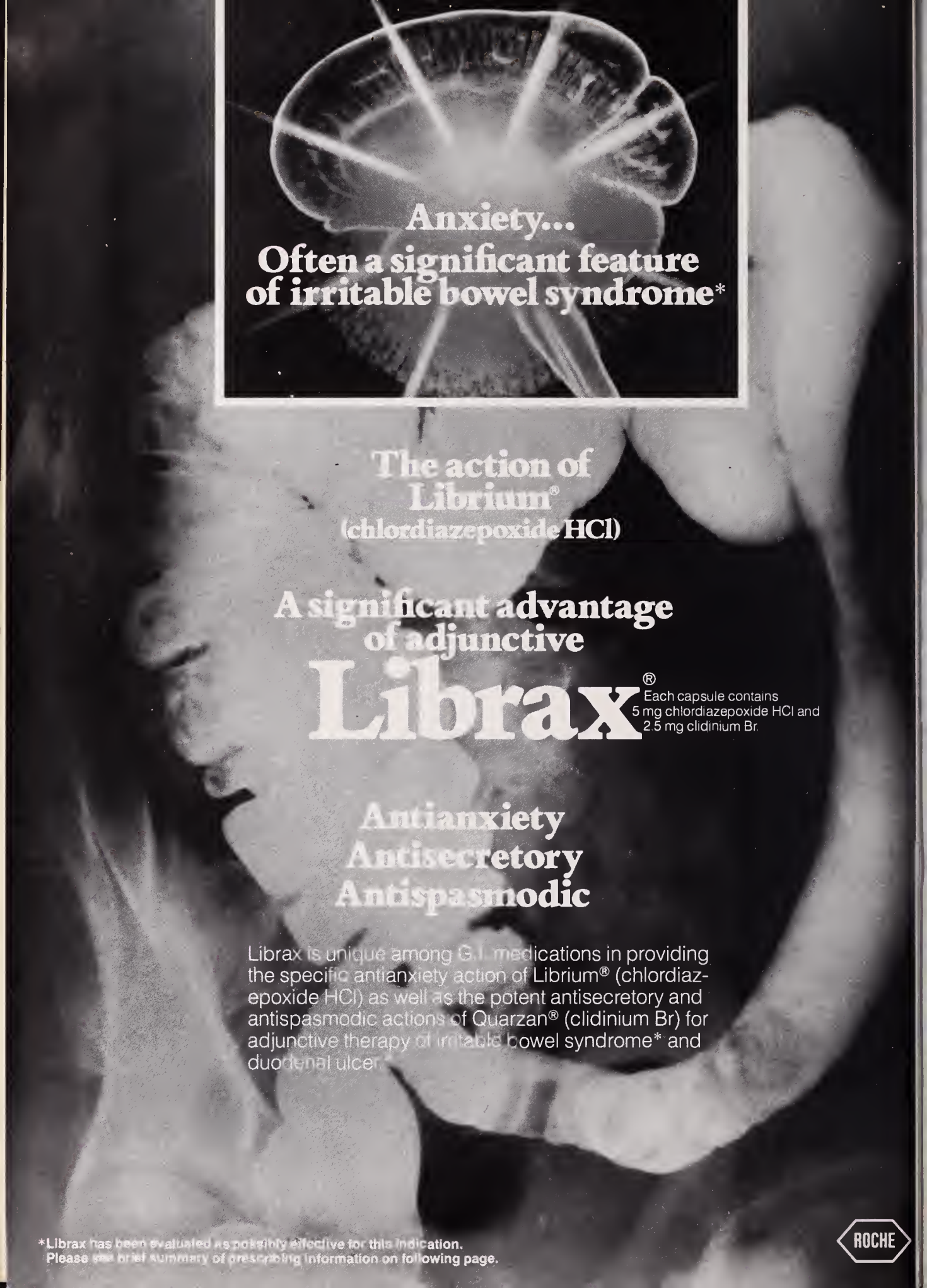
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LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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State Medical Society of Wisconsin

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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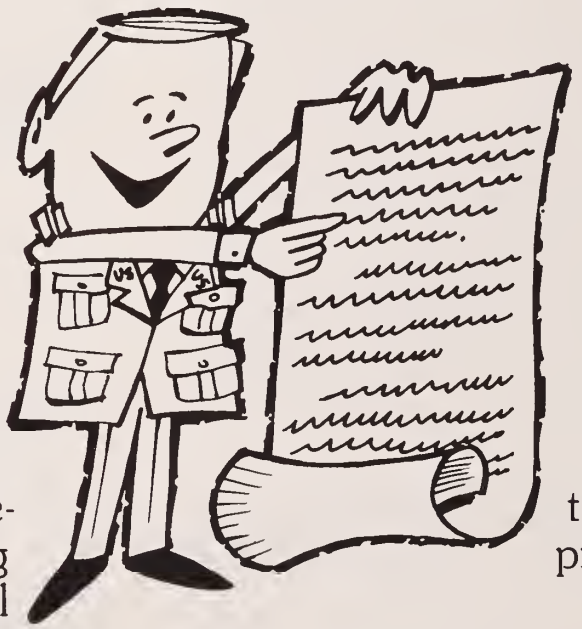

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MEDICAL EXAMINING BOARD TO HOLD HEARING ON AMPHETAMINE BAN

The State Medical Examining Board will hold a public hearing on January 18, 1978 in Room 127, 1400 East Washington Avenue, Madison, Wisconsin at 9:00 a.m. to consider amending its November 1, 1977 ruling that banned virtually all sales and prescriptions of amphetamines in Wisconsin. The Board plans to amend Chapter Med. 10.02(2) (s) of the Wisconsin Administrative Code to clarify what drugs will not be available to physicians for prescription. The proposed amendment reads (strike-over words, deleted; italicized words, added):

10.02(2) (s) "Prescribing, ordering, dispensing, administering, supplying, selling or giving any *amphetamine,* ~~drug or compound or derivative, congener or analogue thereof,~~ *sympathomimetic amine or isoindol drug or compound designated as a Schedule II, III or IV controlled substance pursuant to the provisions of Chapter 161 Wis. Stats.* to or for any person except for the treatment of drug-induced brain dysfunction, *or for the treatment of epilepsy,* or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the Board before such investigation has been begun."

The Society is studying this matter but has already expressed its strong view that the Board should be quite specific as to what drugs are included in this ban. Interested physicians are invited to testify at the above-mentioned hearing.

In related action, Judge Torphy of the Dane County Court has stayed the Medical Examining Board's original ruling on amphetamine prescription with regard to Tenuate and Tenuate Dospan at the request of the Merrell-National Drug Company.

PUBLIC DISCLOSURE OF T-18 PAYMENTS TO PHYSICIANS

All Medicare contractors (such as Wisconsin Physicians Service [WPS] and Surgical Care) now are required to make all Medicare payment information available to the public. This new requirement is part of the "Government and Sunshine Act" which became effective March 12, 1977. The information to be made available will include both total payments made to physicians on assigned claims and payments made to patients of each provider on nonassigned claims. The Secretary of HEW has determined that the release of this type of information does not constitute an unwarranted invasion of privacy of the provider. SMS has filed a protest to the proposed release as costly and of little useful purpose.

Medicare carriers will release the following types of information on an annual basis to the public for inspection: (1) Physician's name (2) Physician's address, and (3) Medicare payments, both assigned and nonassigned. Before February 1, 1978 all information to be released by the carriers on April 30, 1978 will be sent to each physician. The physician will then have 30 days to review the data and call to the carrier's attention any discrepancies. This report to the carriers must be in writing and indicate the reasons for the requested change.

MEDICAL SCHOOL ENROLLMENT INCREASE

Total enrollment in the 116 US medical schools in 1976-77 was 58,266, an increase of 2,022 over the previous year, according to an annual report on medical education recently published by the AMA. The total number of women enrolled in 1976-77 was 13,059, an increase of 1,532 over the previous year. By 1981-82, the 116 medical schools project a first-year class of more than 16,000, with more than 16,000 graduates each year. Some additional medical schools will be in operation by that time. ■

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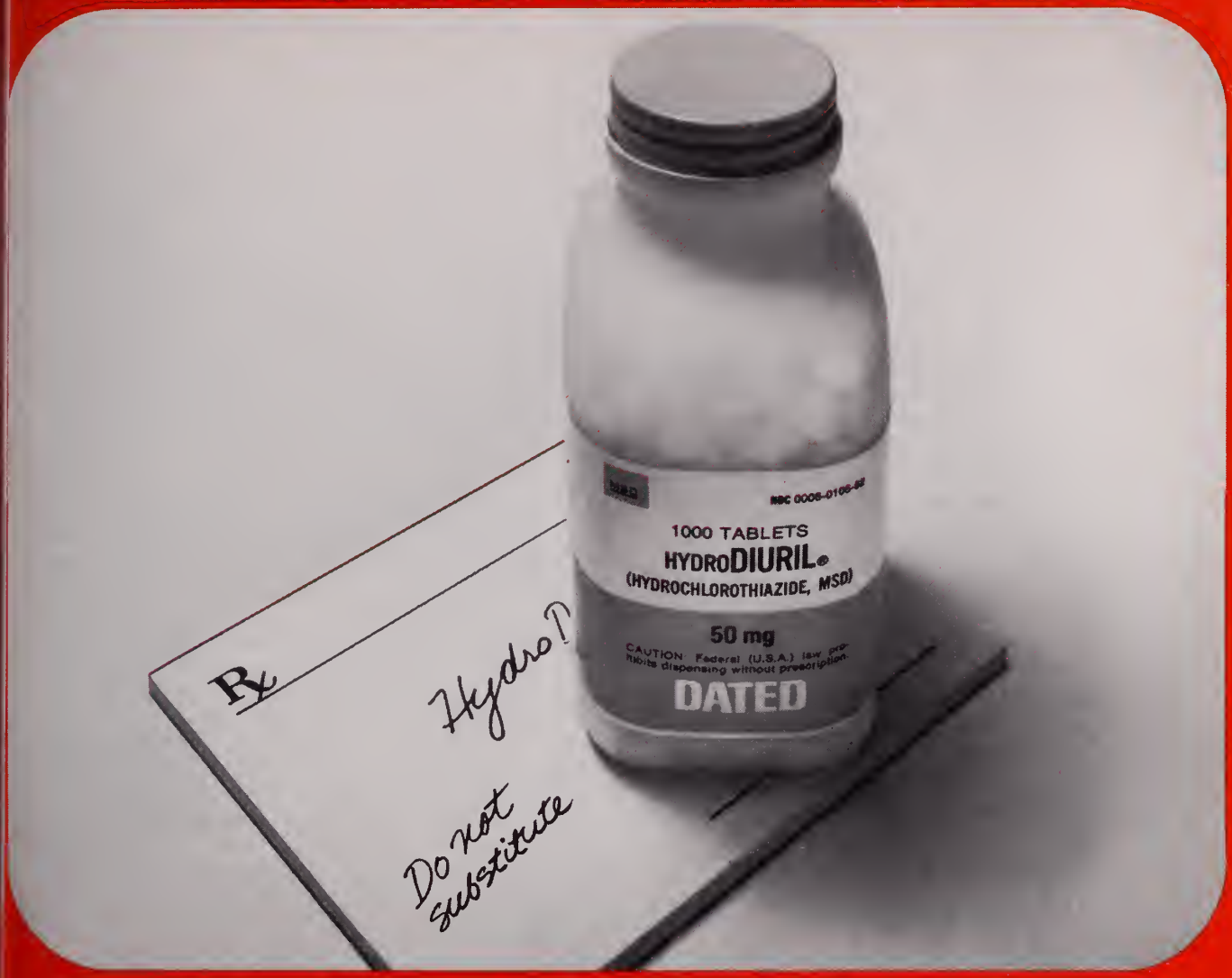
Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



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pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

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Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.
Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.
Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).
Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.
Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.
Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

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Family practitioners and surgical privilege

On June 19, 1977 the Wisconsin Academy of Family Physicians adopted a resolution regarding surgical privileges quoted herein in part: "Resolved, that surgical department rules of Wisconsin hospitals be revised where necessary to grant surgical privileges to those members of the Department of Family Practice commensurate with their surgical training, experience and demonstrated ability . . ."

A few weeks ago a front page article in the *Chicago Tribune* quoted a leading surgical educator as having said that a large percentage of operations performed in the United States are done by untrained surgeons. That point has been made many times before and has been used as an argument by those who favor the continuation of the training of large numbers of surgeons. It takes on additional significance now, however, as hordes of family practitioners will be completing residencies and opening practices in communities where there are plenty of fully qualified surgical specialists to go around.

No doubt many of these young physicians will have been taught to perform such operations as herniorrhaphy, appendectomy, and D and C, to do obstetrics and fracture work; and they will wish to continue along that line in practice. Therein lies the dilemma.

On the one hand medical school graduates are urged to go into family practice by the federal government, and medical schools are granted subsidies to train them as all-purpose physicians. Yet on the other hand, government stresses more and more that quality control must be a part of the hospital scene, and that certification and recertification are essential if one is to retain surgical privileges. Can a hospital credentials committee act responsibly in such a philosophical tug of war?

It has been said that even a baboon can be taught to do surgery. (After 20 years of teaching surgical residents I am inclined to agree.) But while the technical aspects of surgery can be mastered by most physicians, surgical judgment comes harder and slower, and it simply can't be acquired in a six-month or one-year rotation through the surgical specialties.

And even if the young family practitioner does demonstrate aptitude in performing these surgical procedures, is the chairman of the department of surgery going to grant him privileges if a young surgeon on his staff just out of a five-year training program hasn't enough work to keep his skills honed?

These questions will have to be faced head on in each hospital, and solutions may vary depending on the community, the character of the hospital, the local availability of surgical specialists, and even the personalities involved. Above all, we must be fair. Family practice residency candidates must be told the facts of life as they exist in the communities they plan to serve before they become committed.

Those responsible for recruiting and training these people can't hand the graduates their certificates and push them out into the snow. They must assist in placing them in communities where their level of surgical expertise is needed and acceptable. But they must also keep in mind that if there is to be quality control in surgery, then the surgery has to be done by qualified surgeons.—WJB

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Victor S Falk, MD, Edgerton

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

75th anniversary of the Wisconsin Medical Journal

JANUARY 1978 MARKS the 75th anniversary of the first publication of the *Wisconsin Medical Journal*. Although the first issue of the journal appeared in 1903, the idea of a publication was born much earlier. In 1860 the following resolution was passed by the House of Delegates of the State Medical Society:

> *Resolved*, that in the opinion of this Society a Medical Journal designed to record the experiences of the members of this Society is essential and should be established."

The result of this was the publication of the "Transactions of the Wisconsin Medical Society" from 1868 until 1902.

The *Wisconsin Medical Journal* itself was not published until January 1903. At that time a group of physicians organized the Wisconsin Medical Journal Company, for the purpose of publishing "A monthly

journal . . . . . owned by and devoted to the interests of the medical profession of this state". Doctor Arthur J Patek of Milwaukee was its first editor.

The prophetic editorial comment which introduced the first volume stated:

> "We are blessed with laws regulating the practice of medicine, but appreciate, too, that they are inadequate to properly protect the rights and safety of the physicians and the public. With 3,000 physicians in practice, and an annual increment of about 100 or more, we feel that there is a place here for an organ championing the cause of the physicians, for the physicians, and for the public.
>
> "We will aim, in our editorial utterances, to avoid the shoals of factional strife, to court no 'entangling alliances', but to encourage and recognize good work wherever it is being carried on."

At the annual meeting of the State Medical Society in 1902, a unanimous vote was cast to publish the transactions of the Society in the *Wisconsin Medical Journal,* thus making it the official organ of the Society. However, it was not until 1910 that the Journal actually became the property of the members of the Society. Publication was carried out in Milwaukee until 1929 when the Society offices were moved to Madison.

Since 1903 there have been nine medical, or scientific, editors of the *Wisconsin Medical Journal.* The first five were all from Milwaukee and in addition to Doctor Patek, there were Doctors A W Myers, L M Warfield, Rock Sleyster, and John Huston. There were two periods when there was no medical editor but the Editorial Board functioned in that capacity. From 1938 to 1962 the editorship was held by three different members of the staff of the Marshfield Clinic. These were Doctors Paul Doege, Karl Doege, and Robert Baldwin. The present editor has held office since 1962. —VSF

Disclaimer

In a recent meeting the Council of the State Medical Society voted to give the Editorial Director and the Editorial Associates *carte blanche* in their editorial freedom. This action was taken because of a number of controversial editorials that had been held in abeyance because of considerable disagreement.

Since the *Wisconsin Medical Journal* is the official publication of the State Medical Society of Wisconsin, it must be realized that the editorial expressions are

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those of the author only, and may not necessarily reflect the policies or attitude of either the Council or the Medical Society. The initials of the author appear at the end of each editorial.

With this in mind a couple of hot potatoes follow.
—VSF

South of the border (down Rockford way)

For many years some physicians in southern Wisconsin have been puzzled and union shop stewards and committeemen have been plagued by the failure to come up with an answer to a recurring question. It involves elective sterilization, either male or female, in employees (6,000 of them in a single large industry) who have found that the procedure is specifically excluded in their insurance coverage by Wisconsin Physicians Service. Strangely enough, it is excluded only if the surgery is performed in Wisconsin, but is paid if the patients cross the state line and have the surgery done in Illinois. It is especially puzzling since the surgical charges in northern Illinois are generally considerably higher than they are in southern Wisconsin.

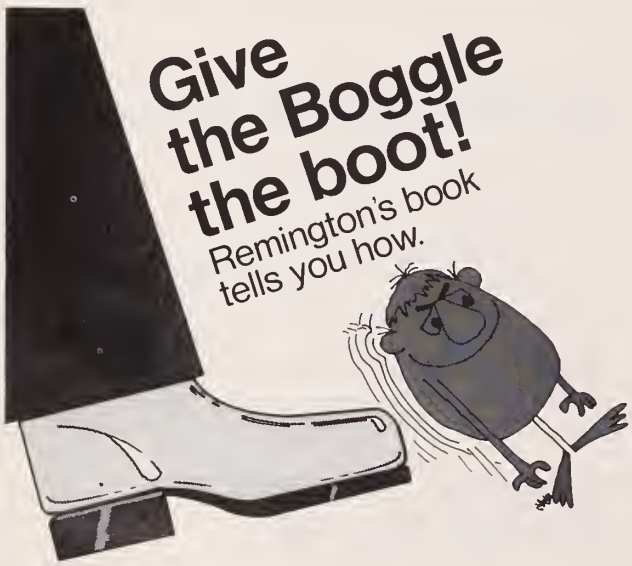
So the patients who elect to have surgery done in Wisconsin in addition to being vasectomized are claiming they are being victimized as well. What's the answer?—VSF

Brief Friendship

In the October issue of the *Wisconsin Medical Journal,* there appeared a brief editorial that commended the Council of the State Medical Society and the Physicians Alliance Medical Defense Committee for supporting a professional liability suit with a "friend of the court" brief. The commendation apparently was premature and the friends are not going to court.

The case involved a pathologist who appeared as an expert witness in an orthopedic situation. It is most unlikely that the pathologist had ever treated a patient with a compound fracture of the humerus in his entire medical career. In the meantime the orthopedic surgeons have put out thousands of dollars on their own behalf. What happened to their "friends"?

The original editorial contention was that a physician who may be an expert in one relatively isolated field be permitted to testify as an expert across the board in totally unrelated specialties was an untenable situation. This still stands. But what changed the decision of the Council and Committee?—VSF ■



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VSF who?

To the Editor: Much as we would all like to consider ourselves to be famous, or at least well known, this is rarely true. Accordingly, the editorial page of the *Wisconsin Medical Journal* lists the editorial director and editorial associates by name so their initials can be traced.

However, "VSF" signs many editorials but is otherwise unidentified. His opinions are worthy of consideration so he should feel no shame and not hide in the shadows. I have been able to find out who he is, but others may not have been so fortunate.

Please do identify "VSF" by name and position, with the other editorial writers, in each issue of the *Wisconsin Medical Journal.* Thank you.

MARTIN FRUCHTMAN, MD
Waukesha, Wisconsin

December 6, 1977

To Doctor Fruchtman: Your letter requesting the identity of VSF was forwarded to me. Apparently in my fifteen years as Medical Editor of the *Wisconsin Medical Journal* I haven't made much of a splash. On the other hand, if anyone turned back about one page to the masthead of the Journal my name has appeared at the top of the column as Medical Editor since 1962.

Periodically Medical Editors exercise their editorial prerogatives and do write editorials. At other times the Editorial Associates have not been particularly productive and a contribution is needed to meet a deadline.

Perhaps I can prevail upon the Council to list me an an ex-officio member of the Editorial Associates in the future. Anyway, it is nice to know that someone is reading the Journal and expresses an interest in it. Thanks for your letter.

V S FALK, MD
Edgerton, Wisconsin

December 12, 1977

MANAGING EDITOR'S NOTE: The WMJ concurs with both of the above letters, and starting with this issue Doctor Falk's name will appear on the editorial page masthead. ■

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

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A QUARTERLY COMMUNICATION TO PHYSICIANS JANUARY 1978

"KXY PXOPLX"

> Xvxn though my typxwritxr is an old modxl it works quitx wxll, xxcxpt for onx of thx kxys.

Do YOU REALIZE that your medical assistant is one of the key people in your office? Frequently she is the first contact that a patient has with your office. She may speak with the patient by telephone to make an appointment. She may greet the patient when he or she arrives. She may assist you during the examination. She may answer some of the questions that the patient may have. She may handle the insurance and payments.

> I havx wishxd many timxs that it workxd pxrfxctly and whilx it is trux that most of thx kxys function wxll xnough, just onx kxy not working wxll makxs a big diffxrxncx.

Medicine is a constantly changing field. New medical and surgical techniques are being developed. New medicines are being introduced. As a physician, you are expected to keep up with all of these changes. The State of Wisconsin has made it mandatory that by 1980 you show proof of continuing education in order to retain your license to practice medicine. So you will be keeping abreast of the changes—but what about your medical assistant?

> You know, your officx can bx somxwhat likx my typxwritxr if all of thx kxy pxoplx arx not working propxrly.

You have seen articles in the *Wisconsin Medical Journal* concerning the American Association of Medical Assistants, and probably recall that this organization is made up of people, mostly women, who work directly for or under the supervision of a doctor of medicine. One of the main purposes for the existence of the AAMA is continuing education. In order to offer its members the latest information available, the AAMA provides Professional Development and Advancement Seminars, Leadership Training Programs, and Annual Meetings as well as monthly meetings at a chapter or county level.

> Now you may say to yoursxlf, my mxdical assistant is only onx pxrson and shx won't makx or brxak my officx; bxsidxs, shx has bxxn with mx for yxars.

It is possible though for a person to work at a job for years and still not fully comprehend it. It is also possible to attend lectures and programs and not really grasp the ideas that are presented. So it can be very difficult for you to really know for sure whether or not your medical assistant is keeping up to date. If she is attending all of the programs offered by the AAMA, she certainly is being *exposed* to the latest information; but how much of this is she retaining? The AAMA can help you and your medical assistant to answer that question.

> For it doxs makx a diffxrxncx; bxcausx any officx, to bx xffxctivx, nxxds a knowlxdgxablx staff of profxssional pxoplx.

The AAMA has established a Certification program, which is sponsored by the American Medical Association, and the questions on the Certification examination are prepared by the National Board of Medical Examiners. The purpose of this program is to test the competency of a medical assistant in various fields. Any medical assistant may apply to the AAMA and sit for the examination, which is given twice a year at selected test centers throughout Wisconsin. Only those who pass this in-depth examination are awarded the coveted status of Certified Medical Assistant, or CMA. And this is just basic knowledge! After achieving her CMA, a medical assistant may then further prove her capabilities in either the Administrative or Clinical specialties through another section of examination. But—that is still not the end! For in 1980 she, too, will have to prove that she is keeping abreast of the changes in the field of medicine and will have to be re-Certified. This can be done by either rewriting the examination or by showing proof of continuing education, which is offered through AMA-AAMA approved programs.

> So, xvxn though most of thx kxys function wxll xnough, just onx kxy not working wxll makxs a big diffxrxncx.

And your medical assistant is a key person in your office. Do you encourage her to belong to the AAMA? Are you giving her your moral support as she considers the Certification examination? Or, if you happen to have one of Wisconsin's 193 CMAs working for you, have you discussed the re-Certification program with her?

> And thx nxxt timx that you think that your mxdical assistant is only onx pxrson and that hxr xfforts arx not important, just rxmxmbxr my typxwritxr.

If either you or your medical assistant would like to have more information about the AAMA or its Certification program, please contact Mrs Leora Lee, CMA-AC, Chairman of the Certification Committee, 1017 Shirland Avenue, Beloit, Wisconsin 53511.

—LEORA LEE, CMA-AC ■

Physicians' political abilities extend beyond medicine's problems

WINSTON CHURCHILL once commented that he believed political ability to be the ability to foretell what is going to happen tomorrow, next month, and next year—and the ability to explain why it didn't happen. While I certainly will not attempt to challenge the general nature of that profound statement, I would however like to propose an alternative that I feel is applicable to the political ability of an entity such as the State Medical Society.

The political efforts of an organization such as SMS ought to combine not only an ability to predict the position of medicine and health care in society in coming days, weeks, and years, but also an ability to propose and promote concepts that might be beneficial to that very society. I believe that it behooves medicine, in this case the State Medical Society as a representative of over 4600 physicians in Wisconsin, to comment on the merits of governmental (and other) programs that may affect the general quality of life of Wisconsin citizens. It is only then that physicians assume a prominent position in the political process; our contribution to that process cannot only be in the areas from which medicine may derive either a direct benefit or where we may protect our current sphere of responsibility.

LUBITZ

To be sure, a prime responsibility of SMS must be to protect the socioeconomic interests of physicians, whether it be in the area of professional liability or government regulation. Also we must be ever concerned about the increasing level of encroachment on the practice of medicine by other groups and self-proclaimed practitioners of health care.

The fact that the State Medical Society's House of Delegates created the Physicians Alliance Division gives these prime responsibilities their proper emphasis within the SMS organizational structure. I would suggest, however, that our efforts in these "prime" areas will be aided a great deal by what is a developing ability on our part to propose, comment on, and work for changes in other areas of legislative concern.

A good example of this new area of responsibility is illustrated by the creation of the Committee on Environmental Health. At its first meeting on December 14, 1976 this new standing committee of the Commission on Governmental Affairs heard from Mr Anthony Earl, Secretary of the Wisconsin Department of Natural Resources. The primary direction of Mr Earl's comments was that the State of Wisconsin, and his department in particular, needs the input of Wisconsin physicians on environmental matters. He candidly admitted that the current activities of DNR seldom include an analysis of what department activities and decisions may mean to the health of Wisconsin citizens. This is clearly an area in which the State Medical Society as well as individual physicians may not derive any "organizational" gains, but represents an activity that is rightfully a *duty* of physicians on behalf of the public.

I would suspect that whenever the Legislature considers such issues, it too sorely lacks input from a health perspective. However,

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organized medicine should, and is, moving to fill that gap. This effort will naturally take a great deal of time; the committee members were all too aware of this when they briefly examined the magnitude of the "environmental issues" facing the current Legislature.

Another example of a subject area that begs for physician input, both in the legislative and the public arenas, is the need for increased emphasis on nutrition. I was pleased to see that the Goals and Objectives Statement for SMS for 1978 includes SMS Council responsibility for a State Medical Society statement or position on nutrition. I am aware that some staff members at the Society have received inquiries from citizen groups about the nutritional value of some public meals programs, as well as the presence of "junk food" in the meal programs at some Wisconsin schools. What better group to carefully examine the impact of this issue on the health of Wisconsin school children than a group of personally concerned physicians?

A natural question that surfaces at this point is how these efforts might impact on the "political ability" of SMS as mentioned earlier. Physicians in this state are now in a rather unique position, in that we now have an opportunity to assist others, in particular the Legislature, in resolving a host of public problems without any consideration of what impact those decisions might have on the physician as an organized segment of the citizenry. Many of our current legislative activities are designed to directly benefit or protect the physician, and rightfully so. We have here an opportunity to also assist society in general, without the promise or need for personal reward. That, I submit, is a more lofty and down-to-earth responsibility of medicine. In addition, I would not attempt to ignore the fact that our activity in these other areas will directly impact on our own standing with the Legislature and others when the more traditional concerns of medicine are considered. We have a responsibility to our membership to be a "special interest" group; we also have a responsibility to the citizenry to act in their special interest as well.

JOSEPH M LUBITZ, MD
Chairman, Commission on Governmental Affairs
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Cancer staging strategies

CAREFUL STAGING of cancer is essential for choosing the best possible treatment, reliably evaluating treatment results, estimating patient prognosis, and comparing recurrence and survival statistics for various methods of treatment. Any classification system which is used is manmade and imposes human concepts of order on observed phenomena and accumulated experience. Proper staging of a tumor may require information obtained by physical examination, diagnostic procedures, surgery, and histopathological examination.

Since many of the present methods of staging are not exact, the American Joint Committee (AJC) for Cancer Staging and End Results Reporting recently prepared a *Manual for Staging of Cancer, 1977*,[1] which is available at no cost. As far as possible the AJC has tried to develop classifications for cancers of the different anatomic sites, which are compatible with other older systems, those published by the International Union Against Cancer (UICC), and that are within the current standards of American medical practice. The AJC also recommends that the *International Classification of Diseases for Oncology (ICD-O)*[2] be used to code neoplasms by topography and histology and for indicating behavior, such as malignant, benign, in situ, uncertain, or metastatic. This nomenclature is based on the *Manual of Tumor Nomenclature and Coding*.[3]

Where appropriate, the AJC has used the *TNM* system, which is based on clinical features supplemented by microscopic examination. Any clinical classification should be applicable to cases of a particular cancer at all times regardless of the treatment used. In general, the suggested method is useful, flexible, and easily applied.

In the *TNM* system, the letter *T* represents the primary tumor with number suffixes to describe increasing tumor size, involvement by direct extension, or both; the letter *N* represents the regional lymph node involvement with numerical suffixes describing the absence of involvement or increasing degrees of tumor dissemination; and the letter *M* represents distant metastasis, with the suffixes denoting the absence of metastasis or increasing degrees of tumor metastasis. If the letter *X* follows the *TNM* designation, it indicates that no assessment of the lesion is possible. Prefixes are also used: *c* denotes clinical-diagnostic staging; *s*, surgical-evaluative staging; *p*, postsurgical treatment and pathologic staging; *r*, retreatment staging; and *a*, autopsy staging. The specific amount of involvement is thus carefully defined for each individual tumor.

The *TNM* staging system for head and neck cancer, which has been in common clinical use for a number of years, is based on the best possible clinical estimate of the extent of the disease. Surgical evaluations and pathologic classifications are possible but have been of less practical importance in the handling of these tumors.

The AJC has recommended a new staging system for soft tissue sarcomas, tumors for which no generally recognized staging system has previously existed. Staging of soft tissue sarcomas uses the histologic type and grade of the tumor in addition to clinical information to develop a meaningful staging system. The histologic diagnosis which identified the type of tumor and the pathologist's assessment of the inherent degree of differentiation of that tumor type are fundamentals on which this staging is based.

The *TNM* staging system for carcinoma of the breast has been increasingly utilized in the last five years. The staging system for breast cancer was recommended jointly by the UICC and AJC and tried from 1973-1977. Only minor changes have been made in the *TNM* definitions for clinical-diagnostic staging, but the definitions for postsurgical treatment-pathologic classifications and the stage grouping have been changed. With *in situ* and infiltrating cancer of the breast, histologic verification is also mandatory.

The AJC has developed a new staging system for colo-rectal carcinoma. The common older classification is Dukes which was originally developed only for rectal carcinoma. Dukes classification depends on the degree of anatomic spread and the presence or absence of nodal metastases. Staging in colo-rectal carcinoma has been used to provide a fairly accurate prediction of prognosis, rather than treatment planning, but it has become increasingly useful in therapeutic decisions. It has been derived from the interpretation of permanent histologic sections of the colonic tumor and its draining lymphatics. The *TNM* system recommended by the AJC clearly defines the level of penetration into the bowel wall, something which was not always done by modified Dukes staging systems for colon carcinoma.

With increasing use of standardized staging systems, such as those recommended by the AJC, the extent of disease may be more accurately determined, patients may receive better and more appropriate treatment, measurements of treatment results improved, and the results of different types of treatment or sites of treatment more easily compared.

REFERENCES

1. American Joint Committee for Cancer Staging and End-Results Reporting. *Manual for Staging of Cancer. 1977.* American Joint Committee, 55 East Erie Street, Chicago, Illinois 60611.
2. World Health Organization. *ICD-O—International Classification of Diseases for Oncology*, WHO, Geneva, 1976.
3. *Manual of Tumor Nomenclature and Coding.* American Cancer Society, 1968.

—DOROTHY J BUCHANAN-DAVIDSON, PhD and ERNEST C BORDEN, MD
Wisconsin Clinical Cancer Center

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

CANCER COLUMN

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Cancer conferences

A Colon-Rectal Cancer Conference will be held Saturday, February 25 at the Red Wing Area Technical Institute, Red Wing, Minn.

The Tenth Annual Southeastern Wisconsin Cancer Conference will be held Saturday, April 1, at the Pfister Hotel in Milwaukee, Wisconsin.

Both conferences are reported in detail in the YELLOW PAGES section of this issue. ■

GAC endorses AMA marijuana position statement

The AMA House of Delegates' Position Statement on Marijuana received the SMS Commission on Governmental Affairs' endorsement at its December 14 meeting.

The AMA statement recommends elimination of criminal penalties for possession of small amounts of marijuana, substituting penalties for the trafficking of marijuana.

Speaking for the Commission, Chairman Joseph M. Lubitz, MD said, "It is our belief that a person should not be subject to arrest, imprisonment, and a criminal record for simple possession of small amounts (of marijuana). Criminal penalties are far out of proportion to the individual or social harm that may come from the offense."

In other action the Commission:

• Directed staff to draw up legislation regarding: (A) immunity for MDs reporting to or assisting the State Medical Examining Board, (B) mandatory reporting to the State Medical Examining Board of disciplinary actions taken by hospitals and professional societies, and (C) State Medical Examining Board reports to professional societies and accreditation entities.

• Opposed AB 281 and its substitute amendment 1, which would allow optometrists who complete a single course in pharmacology to administer diagnostic drugs to their patients. The amended bill would allow optometrists to treat adverse reactions to drugs. In its opposition to AB 281, the Commission stated optometrists are not adequately trained to deal with adverse reactions.

• Requested staff to work on AB 159, which would allow psychologists to perform therapeutic, diagnostic, and consultative services, regardless of whether they are performed with approval, supervision, or referral from a physician.

• Supported AB 1039, which expands the membership of county health commissions and county boards of health to include registered nurses with experience in county health functions.

• Supported SB 159, which as amended, prohibits smoking in government-owned buildings. This position taken by the Commission is consistent with the 1972 House of Delegates' position.

• Supported AB 1082, which authorizes the State Pharmacy Examining Board to exempt more nonprescription drugs from the current law that prohibits the sale of drugs, medicines, or poisons except by registered pharmacists. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.19 as of October 31, 1977. ■

Council endorses uniform claim form

On December 10, the SMS Council endorsed recommendations from the Physicians Alliance Commission on a uniform claim form and billing procedures to obtain more prompt reimbursement of claims for health services rendered by providers. These endorsements include:

(1) Accept the AMA uniform claim form as the standard health insurance claim form for use by physicians' offices in Wisconsin with all third party carriers including Medicare and Medicaid.

(2) Adopt the CPT-4 procedure (service) code for reporting of services to all third parties beginning January 1, 1978 with full implementation no later than July 1, 1978. (CPT-4= *Current Procedural Terminology*, 4th edition, published by AMA)

(3) Adopt the HICDA diagnosis code for the reporting of services to all third parties beginning January 1, 1978 with full implementation no later than July 1, 1978. (HICDA = Hospital International Classification of Diseases Amended)

(4) Work with EDS (and other carriers where possible) to develop a uniform coding for supplies and equipment used in physicians' offices.

(5) Form an advisory committee to work with the State Health and Social Services Department (DHSS) to evaluate proposed new procedural changes or rules on Title 19 (Medicaid).

The Physicians Alliance Commission will create a special Physicians Alliance-Clinic Manager Committee to implement the transition from multiple procedure codes in current use to the uniform CPT-4 coding. EDS has agreed to work with such a committee to assure agreement and consistency of interpretation between the various codes. ■

Other Council action on December 10

Meeting in Madison on December 10, the Council:

• Elected nine additional public members to the Wisconsin Physicians Service Insurance Corporation (WPSIC) Board of Directors. The Bylaws of WPSIC calls for 30 members with one less than half being public members. Following was a meeting between the WPSIC Board and the State Medical Society Council acting as the corporate membership.

• Accepted a statement of SMS goals, objectives and projects for 1978 as a working draft to be monitored by the Executive Committee. The Council identified specific projects to be undertaken by the Society with primary emphasis placed in the following areas: (1) increasing membership strength through improved communications with the membership and relationships with specialty societies;

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(2) maintaining and improving legislative efforts; (3) strengthening peer review activities; (4) continuing to provide quality membership services, such as representing physicians' interests in the Wisconsin Title 19 Medicaid Program, and (5) expanding SMS's role in health planning.

• Approved a budget of $1,271,000 for 1978 as proposed by the Council Finance Committee.

• Agreed to disband the Ad Hoc Committee on Chiropractic and transfer its duties to the Governmental Affairs Commission. The Council also thanked the Committee for its past contributions.

• Announced the retention of a public relations consulting firm for the Society. An initial report by the firm has been sent to the Commission on Public Information for review.

• Approved installation of an in-house WATS line for the Society for sometime in January 1978. The purpose of the WATS line is to increase the accessibility of Society staff to members.

• Directed appointment of a Medical Quality Care Committee representative of WHCRI, WisPRO, FMCE and SMS, to further evaluate a private sector quality assurance peer review proposal of WHCRI as well as working relationships between the various organizations, and report to the Council on February 4.

• Agreed to have the Commission on Cost Evaluation and Delivery of Medical Care review a report recently issued by the National Commission on the Cost of Medical Care and present its report to the Council on February 4. ■

JUNE 1977 BLUE BOOK UPDATE

In the Presidents and Secretaries, Wisconsin Specialty Societies, on page 87 of the June 1977 *Blue Book*, the following changes have been made:

Wisconsin Allergy Society
President: Raymond L Hansen, MD
(Sept 1979), 1000 N Oak Ave, Marshfield 54449
Secretary: William Busse, MD
(Sept 1979), 504 N Walnut St, Madison 53706

Wisconsin Radiological Society
President: Donald P Babbitt, MD
(Sept 1979), 1700 W Wisconsin Ave, Milwaukee 53233

Wisconsin Society of Obstetrics and Gynecology
President: C Weir Horswill, MD
(July 1979), 2630 Amherst Rd, Middleton 53562
Secretary: Michael Stevens, MD
(July 1979), 1000 N Oak Ave, Marshfield 54449. ■

Environmental Health Committee has initial meet

The recently named members of the newly organized Committee on Environmental Health met for the first time in December at SMS headquarters in Madison.

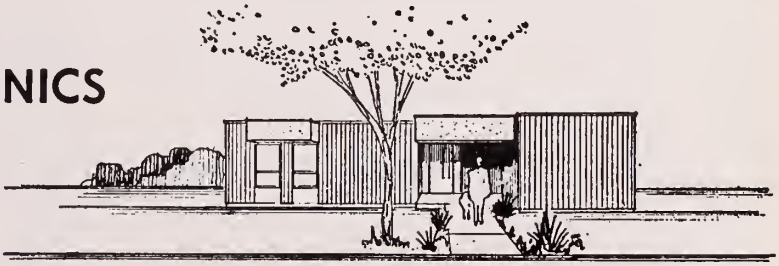
The nine-member committee is headed by Wendelin W Schaefer, MD of Sheboygan. Other members are: MDs Carl Zenz, West Allis; George E Cassidy, MD, Manitowoc; Phillip M Green, Marshfield; John T Schmitz, Milwaukee; Nunilo Bugarin, Tomahawk; Frank A Walker, Brookfield; Melvin Blumenthal, Monroe; and Larry Lindesmith, LaCrosse.

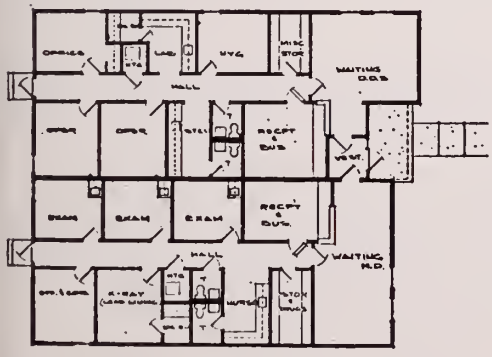
The committee met briefly with Anthony Earl, secretary of the State Department of Natural Resources.

The environmental committee is a subcommittee of the SMS Commission on Governmental Affairs. It has been established to develop "informed and realistic positions on matters pertaining to health and the environment."

Chairman Schaefer expects "the new committee will make it possible for the State Medical Society to adequately respond to legislator's inquiries involving environmental matters from the health perspective." ■

MEDICAL & DENTAL CLINICS





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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

October 15, 1977—Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 1:00 pm on Saturday, October 15, 1977, at the State Medical Society.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Councilors Boulanger, Schmidt, Foley, Bruhn, LaBissoniere, Mullooly, Eisenberg, Tuftee, Waterhouse, Natoli, Lewis, Flaherty, Barrette, Doyle; Past President Picard, President Larsen, President-elect Levin, Speaker Motzel, Vice-speaker Taebel.

Others present: Doctors Nordby, Derus, Twelmeyer, Williams, Dettmann, Scott, Stuff, Viste, Lubitz, Kempthorne, Simenstad; Dr and Mrs Lyons; Messrs Thayer, Maroney, Simms, Jensen, Johnson, Brower, LaBissoniere, Wendle, Brozek, Brown; Mrs Bartel and Miss Pyre.

2. Approval of Minutes of August 6, 1977

Doctor Schmidt suggested rewording in the report of the Committee on Economic Medicine to indicate that the insurance checklist had been prepared by Mr Thatcher at the request of the committee.

On motion of Doctor Picard, seconded and carried, the minutes were approved with such revision.

3. Report of Physicians Alliance Commission

Doctor Viste summarized a written report of Commission activities including planning for a negotiations seminar next March; appointment of a Title 19 Oversight Committee consisting of representation from the Commission, family practice, surgery, internal medicine, and psychiatry; the status of negotiations with the state and EDS to resolve claims payment problems, and other pending matters.

4. AMA-Sponsored Comprehensive Health Care Insurance Act

The AMA House of Delegates in June asked that each state society submit its recommendations with regard to national health insurance to the Board of Trustees and that the latter study and report in December on whether the AMA-sponsored Comprehensive Health Care Insurance Act (HR 1818 and S 218) can be interpreted as vehicles that would permit the nationalization of the private practice of medicine or mandate placing the major burden of health insurance upon any one class of our society.

The Committee on Federal Legislation and Commission on Governmental Affairs reported their belief that the AMA proposal does not "nationalize" the private practice of medicine; that it is a workable alternative to other national health insurance plans currently before the Congress; and recommended that the Council endorse the AMA's Comprehensive Health Care Insurance Act and at the same time offer suggestions that the AMA also consider alternative cost containment measures in response to growing public concern with this issue, stating the following examples:

A. Health education

B. Coinsurance and/or deductibles in any comprehensive national health insurance program

C. Making HSAs more effective

D. Dividends, rebates, or tax credits for people who remain healthy

E. More effective use of physicians committees in hospitals for the review of equipment purchases

On motion of Doctors Larsen-Schmidt, carried, the report and recommendations were accepted by the Council.

5. Criteria for AMA Dues Billing and Remittance and Membership Recruitment

The AMA House of Delegates in June requested that the Board of Trustees and AAMSE prepare recommendations for action in December concerning these issues. The AAMSE report to the Board was presented to the Council with a staff recommendation that the criteria be approved.

On motion of Doctors Edwards-Mullooly, carried, the recommendation was adopted by the Council.

6. Follow-up on Council Planning Meeting at Wausau Scheduled for December

Chairman Haskins proposed that discussion of the consultant's report be held for the December meeting and in the meantime that Council members study it in detail; he further suggested that a longer meeting would be required for this discussion and other business, proposing that the Council begin at 9:00 am and committee meetings be held on Friday. He asked whether the Council wished to have Mr Tom Martin present for discussion of his report.

On motion of Doctors Picard-Mullooly, carried, the Council approved the proposed meeting schedule and requested that Mr Martin participate in discussion of the report.

7. Joint Committee on Health Screening and Immunization

The Council received a report of general recommendations in a communication from Chairman Hankey relative to public immunization programs and related liability questions.

On motion of Doctors Eisenberg-Mullooly, carried, the Council requested that the committee's suggestions be referred first to the Section on Pediatrics and that the Section be asked for nominations of physicians who would like to serve on the joint committee.

Doctor Edwards noted that public health standards differ from those of the Academy of Pediatrics, and hoped that the joint committee would serve to standardize immunization guidelines within the state.

The Council also accepted the recommendation of Doctor LaBissoniere that this committee develop a protocol for adult immunizations, and involve the Section on Internal Medicine and perhaps others in this.

8. Report of Executive Committee

Doctor Larsen reviewed discussions and actions of the committee as reported in its minutes of September 15. The Council acted on the following:

A. Auxiliary Voting Representation on Commissions and Committees

On motion made, seconded and carried, the Council approved and forwarded to the House of Delegates the following proposed addition to Chapter VII, Section 1, of the Bylaws concerning the membership of commissions and committees:

"Membership on such committees and commissions shall be limited to members of the Society and its

Auxiliary. Non-members, who are eligible for membership, cannot be appointed or elected. Persons not eligible for membership in the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such committees or commissions. Such individuals shall not have a vote or the right to hold office."

B. House of Delegates Standing Rule Revision

Standing rule 4. a. provides that "an alternate delegate is alternate for a specific regular delegate and cannot serve as a 'roving' alternate delegate." The 1977 House of Delegates requested the Council to consider a revision of this rule to permit appropriate seating of alternates when delegates are absent.

On motion of Doctors Larsen-Levin, carried, the Council recommended restatement of the rule to permit "roving" by alternate delegates within a county society delegation only.

Doctor Larsen reported further on the October 14 meeting of the committee:

C. Meeting with DHSS Secretary Percy and Deputy Willkom

Doctor Larsen commented on the "satisfactory" discussion held with Messrs Percy and Willkom, and informed the Council of a response just received from Secretary Percy to his proposal for a jointly sponsored, impartial analysis of Dr Andreano's studies on "unnecessary surgery" through Wisconsin Regional Medical Program, Inc. Mr Percy had agreed to a joint study, and the committee discussed methods for devising and funding the study.

On motion of Doctors Larsen-Picard, carried, the Council approved the recommendation for appointment of an ad hoc joint committee composed of appropriate representatives from WHCRI and from the Department of Health and Social Services to devise a method and means and proceed to study the question of "unnecessary surgery" in cooperation with the Wisconsin Regional Medical Program.

D. Private Sector Review Proposal

The committee heard presentations by Doctors Blake Waterhouse and William Rock and requested that their proposals be reported directly to the Council. Doctor Waterhouse discussed his recommendation that the SMS initiate and support a statewide private sector quality care peer review system and that WHCRI would be the ideal vehicle as a multidisciplinary organization with consumer representation. Dr Paul Simenstad discussed the concept of data collection through physician profiling.

After discussion, on motion of Doctors Larsen-Natoli, carried, the Council supported in principle the concept of the private sector conducting quality assurance peer review on a statewide basis and requested that the details of the program by which WHCRI is to accomplish this be developed by WHCRI and returned to the Council for review.

E. WPSIC

(1) Audit at June 30, 1977

The committee received but took no action on the audit by Donald E. Gill and Co. Copies were available for Council members.

(2) Status of Tradename Matter

The latest wording proposed by the WPSIC board of directors was not acceptable to the Society since it would permit use of the name with any business WPS may undertake within the statutes other than the provision of health, accident and disability coverage. Messrs Thayer and Maroney had met with Mr Koenig, and the latter requested the drafting of proposed wording by Mr Maroney.

On motion of Doctors Larsen-Mullooly, carried, the following draft was approved by the Council for submission to WPSIC:

"The membership of Wisconsin Physicians Service Insurance Corporation (WPSIC) and its Board of Directors hereby covenant and request that the Insurance Commissioner of the State of Wisconsin so recognize in a Formal Order that they will not permit the use of the name Wisconsin Physicians Service, or WPS, for any purpose other than for identifying its provision of accident, health, and disability coverage, or activities necessarily and directly related to such coverage.

"It is further agreed that the Formal Order should contain provision that in the event WPSIC desires to quit using the name 'WPS,' its decision shall be so noticed to the State Medical Society of Wisconsin. In such event it is agreed that the tradename shall be registered in the name of the State Medical Society to protect its future use, but neither party from that time forth shall use the name for any purpose without the specific approval of the other.

"WPSIC members and Board of Directors further covenant that WPS will not use the terms 'The Doctors' Plan' and 'The Blue Shield Plan of the State Medical Society of Wisconsin,' or any other phrases or words utilizing the name of the Society or indicating a relationship to it, in any way without the specific permission of and on terms and conditions agreed to by the State Medical Society of Wisconsin. WPSIC shall be allowed to use up current supplies until December 31, 1978; however, no such supplies shall be reprinted, when used up, at any time."

(3) Transfer Agreement and Related Matters

The committee received a status report on other unresolved matters which prevent execution of the Transfer Agreement. Two of these involved the withholding of payment by WPS of severance expenses incurred by SMS and formal notice from WPS as to its intentions regarding the lease of space at 330 East Lakeside after 1978. Doctor Edwards indicated he would provide information on these in the report of the Finance Committee.

(4) Future Relationship Between SMS and WPSIC

Prepared at the request of Doctor Haskins for the Executive Committee and distributed to the Council was information on the principal options available to the Society with regard to future relationships with WPSIC, as follows:

(a) Option A: The corporate membership to assume full, legal and proper responsibility for the conduct of the Chapter 613 corporation known as WPSIC.

(b) Option B: Continue the present passive role re WPSIC.

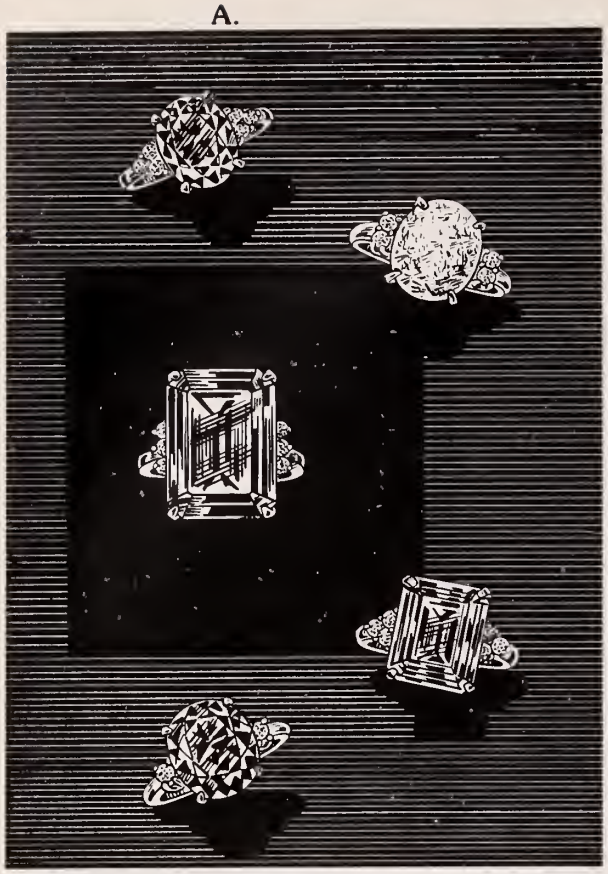
(c) Option C: Complete the separation of WPSIC from the State Medical Society.

(d) Option D: Dissolution or merger.

Prefacing his motion with a statement that the Council had not had opportunity to study the material, and that a recommendation would have to go to the House of Delegates, Doctor Larsen moved the recommendation of the Executive Committee that the Society complete the separation from WPSIC as expeditiously as possible; seconded by Doctor Picard.

Doctor Motzel commented that the Council, as the corporate members, should meet with the WPSIC board in perhaps a full day session, in a "neutral" location, to exchange views with both the physician and non-physician board members, suggesting that such meeting be held after election of the remainder of the

A.



B.

C.

D.

E.

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board and therefore after the first of the year. He moved that the above motion be tabled; seconded by Doctor Eisenberg and carried.

Doctor Larsen then moved that the matter of the options be put on the agenda for the December meeting for discussion and possible disposition at that time; seconded by Doctor LaBissoniere and carried.

(5) Effect of Prior Council Actions on WPSIC Operations

Reported through the September 15 committee minutes and accepted by the Council was the following response to an inquiry by the WPSIC Claims Committee as to whether Council action placing time limitations on fee screen adjustments by WPS was still binding upon WPS in view of separate incorporation:

> "The WPS Board of Directors is completely free at this point to use its own judgment with regard to any matters affecting the operations of WPS so long as these actions do not violate any written agreements with the Council acting for the Society, or are not in violation of any powers reserved to the Council as the corporate membership of WPS."

(6) WPS Board Communication to Insurance Commissioner

In asking for any discussion concerning the September 24 letter to the Insurance Commissioner from the WPS Board of Directors charging interference by the SMS Secretary in WPSIC operations, Chairman Haskins stated that the matter of the Transfer Agreement had been delegated basically to the Executive Committee by the Council, and that Mr Thayer, the staff and legal counsel have acted on explicit instructions. Mr Thayer said he would provide explanations on all 13 points if the Council wished, but he planned no response to the letter.

On motion of Doctors Lewis-Taebel, carried, the Council gave a vote of confidence to Mr Thayer.

F. Trends Toward Independent Practice by Nurse Practitioners

Mr Maroney informed the Council of SMS efforts, in consultation with other interested parties, to develop a prototype for nurse practice situations, especially in view of a recent "declaration of independence" by a group of nurses meeting in Wisconsin. Those presently represented in connection with a specific independent nurse practice arrangement being undertaken in a central Wisconsin location under "sponsorship" of the UW School of Nursing include the SMS Joint Practice Committee, Board of Nursing, Medical Examining Board, UW Center for Health Sciences and Nursing School.

Mr Thayer felt that the problems of independent nurse practice went beyond the scope of the Joint Practice Committee, and suggested the need for an ad hoc committee. Mr Maroney suggested the addition of representation from the UW-Milwaukee and the WAFP to the group mentioned above. This was generally accepted by the Council.

G. Legislative Definition of Death

In view of the fact that several Wisconsin legislators are proceeding with the development of brain death legislation, the Commission on Governmental Affairs requested permission of the Council to proceed with a special study committee chaired by Doctor Levin to work specifically with Representative Czerwinski who requested assistance from the Society.

On motion of Doctors Larsen-Edwards, carried, the Council approved formation of such a special committee.

9. Report of Finance Committee

A. Reduced dues for members new in practice

Doctor Edwards reported that the committee had discussed previous action by which first year's dues for a

member joining the Society within two years of completing internship or residency will be reduced by one-half and clarified the intent that this policy would include one who has been a member as a resident and remains as a regular member upon completion of residency.

The Council requested that this policy be communicated to county medical societies.

B. WPS Audit Report

The committee reviewed the special audit at June 30 and discussed some administrative problems that remain in connection with separate incorporation, related primarily to some $100,000 of unpaid charges to WPS by the Society and Realty Corporation. With the help of Doctor Nordby, it appeared that these matters would be resolved and outstanding amounts paid in full in the ensuing week.

On motion of Doctors Edwards-Levin, carried, the audit report was received and filed.

C. WPS Lease at 330 East Lakeside

Doctor Nordby, as president of the SMS Realty Corporation, informed the committee via a letter from Mr Koenig, that WPS intends not to renew its lease which expires at the end of 1978, and will forgive the unpaid balance of its mortgage which at that time will be about $75,000.

In another administrative matter involving the SMS office services department, the committee instructed staff to attempt to negotiate a written agreement by the end of November which would commit WPS to use the current office services of SMS through 1978, after which the agreement and services would terminate.

D. Budget and Dues

The Committee reviewed expenses through September, which are very close to budget. There is still concern in the area of legal services, but some staff controls have been instituted which should help contain costs.

A recent special membership solicitation of residents and other non-members has to date produced 25 applications; but at the same time over 100 members were about to be dropped from the rolls for nonpayment of dues.

The committee held initial discussion of a 1978 operating budget and recognized as major problems the effects of inflation, limited income sources, and stability of the amount of dues over the past three years. Staff has been instructed to investigate and report on possibilities for additional income sources, and to prepare for another budget session on November 11.

In reference to dues for 1979, the committee recommended that the Council take a position now to recommend to the 1978 House of Delegates that it implement beginning in 1979 the 1975 House action which provided that "future years' dues are to be adjusted annually so as to recognize the inflationary effect on the Society's budget," so that annual dues be structured to reflect, but not to exceed, the annual CPI rate.

On motion of Doctors Edwards-Levin, carried, this recommendation was approved by the Council.

On motion of Doctor Edwards, seconded and carried, the entire report was accepted.

10. Committee on Economic Medicine

A. SMS-WPS Health Insurance Program for Members

Doctor Schmidt summarized a report from WPS on climbing loss ratios because those in the group are aging and younger members are not being added, necessitating substantial rate increases effective December 1: 36% for Plan I and 45% for Plan II. The committee also discussed means for soliciting new member participation in the group, as well as some 40 participants whose continuing eligibility was questionable. As to those who have discontinued membership, it is proposed that at renewal time they be encouraged to reinstate membership to continue as part of the SMS group rather than take conversion coverage at higher premiums and reduced benefits. The committee intends that individual consideration be applied so as to minimize hardship cases.

B. Status Reports

A special committee with representation from the PAC, this committee and the clinic managers, has commenced work on instituting a uniform claim form; a report will be made in December on a proposed new membership category for insurance purposes; reports on the financial status of the WHCLIP suggest the possibility of further premium reductions in the next contract year.

The above report was accepted without objection from the Council.

11. Nominating Committee

Doctor Haskins reported the committee is reviewing nominations from a variety of sources for membership on the WPSIC board of directors. By the December 10 meeting the committee expects to have at least 18 nominations for the nine vacancies.

12. Commission on Mediation and Professional Ethics

Doctor Kempthorne reported on the Commission's review of a physician's practice patterns, including discussions with the physician concerning upgrading of his medical practice and treatment modes, and the recommendation that a planned program of monitoring the situation through on-site visits by Commission members be accepted by the Council as satisfying its earlier directive.

This report was accepted by the Council.

13. WMJ Editorial Policy

Doctor Boulanger, as editorial director and chairman of the editorial associates, requested an expression from the Council as to the direction editorials should take; how aggressive, how free the writers were to state their opinions. It was the consensus that in signed editorials, the writers were free to express an individual opinion, subject to any legal constraints and social propriety. Unsigned editorials are assumed to be an official expression of the Society.

14. Wisconsin Physicians for AMA Offices

Doctor Twelmeyer informed the Council that Doctor Williams has been nominated for a vacancy on the AMA Council on Legislation and requested that contacts be made with AMA Board members known by councilors. The WAFP has urged that Doctor Derus be promoted for a committee appointment and subsequently for election to office in the AMA. The delegation will watch for an appropriate opportunity.

15. Commission on Governmental Affairs

The Council received a written report of status of major bills and members were urged to promote action to secure veto of the chiropractic bill and to support passage of the professional liability bills.

16. National Guidelines for Health Planning

The Council received a copy of proposed guidelines and members were asked to submit comments prior to November 17 when the Commission on Health Facilities and Services will meet to consider an SMS response to HEW by the November 22 deadline.

17. Adjournment—5:30 pm.

EARL R THAYER
Secretary

Approved December 10, 1977
PAUL S HASKINS MD
Chairman

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of November 11, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BROWN

Gallagher, Donald J, 1745 Dousman, Green Bay 54303 (1926, Regular, Obstetrics and Gynecology)

DANE

Bloom, Robert F, 6408 Offshore Dr, Madison 53705 (1947, Resident, Dermatology)
Frazin, Jared A, 1 S Park St, Madison 53715 (1948, Regular, Internal Medicine)
Hert, Robert C Jr, 1013 Milton, #302, Madison 53715 (1949, Resident, Anesthesiology)
Larson, Christopher, 2524 High Ridge Trail, Madison 53713 (1949, Resident, Ophthalmology)
Marek, Robert W, 417 Ridge St, Madison 53705 (1948, Resident, Dermatology)
Winkler, Stefan S, 2500 Overlook Terr, Madison 53705 (1933, Regular, Radiology, Certified)

DODGE

Militello, Joseph M, 1200 N Center St, Beaver Dam 53916 (1943, Regular, General Surgery)

JEFFERSON

Gremmels, Frederick (DO), 1507 Doctors Court, Watertown 53094 (1948, Regular, Family Physician)

MARATHON

Thorpe, Ray M, 400 E Thomas St, Wausau 54401 (1942, Regular, Radiology/Diagnostic Radiology)
Zabel, Earl W, 400 E Thomas St, Wausau 54401 (1945, Regular, Obstetrics and Gynecology)

MILWAUKEE

Brindis, Charles, 2025 Newport Ave, Milwaukee 53211 (1948, Regular, Anesthesiology, Certified)
Hogarty, Thomas J, 4072 N 40th St, Milwaukee 53216 (1947, Resident, Dermatology)
Mathai, George, 2711 W Wells St, Milwaukee 53208 (1937, Regular, Internal Medicine/Pulmonary Diseases)
Rao, Veluvolu K, 1672 S 9th St, Milwaukee 53204 (1949, Regular, Internal Medicine)
Tomasulo, Peter A, PO Box 10G, Milwaukee 53201 (1944, Regular, Hematology/Internal Medicine, Certified-IM)
Waisbren, Burton Jr, 811 E Wisconsin Ave, Milwaukee 53202 (1947, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

OUTAGAMIE

Sullivan, Robert D, 612 E Longview Dr, Appleton 54911 (1945, Regular, Ophthalmology)

SHAWANO

Thomas, Thomas J, 117 E Green Bay St, Shawano 54166 (1948, Regular, Family Physician)

SHEBOYGAN

Deleon, Manuel C III, 708 St Clair Ave, Sheboygan 53081 (1945, Regular, Internal Medicine)
DeRoos, Jan P, 1011 N 8th St, Sheboygan 53081 (1947, Regular, Orthopedic Surgery)
Kapur, Chandra, 203 S Bruns St, Plymouth 53073 (1948, Regular, Internal Medicine)
Perez, Pablo M, 133 E Mill St, Plymouth 53073 (1943, Regular, General Practice/General Surgery)
Slatkin, Alexandre L, 1720 N 8th St, Sheboygan 53081 (1949, Regular, Pulmonary Diseases/Internal Medicine)
Walker, Philip H, 1720 N 8th St, Sheboygan 53081 (1946, Regular, Internal Medicine)
Westcott, Stephen C, 1011 N 8th St, Sheboygan 53081 (1948, Regular, Family Physician)
Windeck, James L, 1011 N 8th St, Sheboygan 53081 (1931, Regular, Family Physician)

WASHINGTON

Beerends, Jerold J, 279 S 17th Ave, West Bend 53095 (1949, Regular, Pediatrics)
Froehlich, James D, 322 S 10th Ave, West Bend 53095 (1947, Regular, Family Physician, Certified)
Wenang, R W, 1004 E Sumner St, Hartford 53027 (1941, Regular, Obstetrics and Gynecology)

WAUKESHA

Cleary, Dan T, 1030 Keats Circle, Oconomowoc 53066 (1945, Regular, Internal Medicine, Certified)
Dall, James E, 1111 Delafield St, Waukesha 53186 (1948, Regular, Family Physician)
Johnson, Collin B, 725 American Ave, Waukesha 53186 (1947, Regular, Pathology)
Konkel, Kurt F, N84W16889 Menomonee Ave, Menomonee Falls 53051 (1945, Regular, Orthopedic Surgery, Certified)
Ulery, David O, 915 E Summit Ave, Oconomowoc 53066 (1947, Regular, Pediatrics)

WAUPACA

Blum, Barton J, 710 Riverside Dr, Waupaca 54981 (1943, Regular, General Surgery)
Huebner, Timothy K, 1041 Hill St, Wisconsin Rapids 54494 (1948, Regular, Family Physician)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Barnes, Haldor P, Madison, to 515 South 32nd Ave, Wausau 54401
Fischer-Williams, M, Madison, to 425 East Wisconsin Ave, Milwaukee 53202
Kiekhofer, William, East Lansing, Mich, to 7949 E 59th St, Tulsa, Okla 74145
Van Riper, Hart E, Deerfield Beach, Fl, to 400 East 54th St, New York, NY 10022

EAU CLAIRE-DUNN-PEPIN

Niver, Edwin O, Chippewa Falls, to 300 Valerie Dr, Waverly, Oh 45690

LACROSSE

Jaeger, John G, LaCrosse, to 56 South Brown St, Rhinelander 54501

MARATHON

Kamat, Pandurang V, Wausau, to 111 W Minnehaha Parkway, Minneapolis, Minn 55419

MILWAUKEE

Goldberg, Nat, Milwaukee, to 881 Ocean Dr, Key Biscayne, Fl 33149
Peterson, John C, Milwaukee, to Rte 2, Box 76, Point Washington, Fl 32454

ONEIDA-VILAS

Farrington, Joseph D, Minocqua, to PO Box 153, Key Coloney Beach, Fl 33051

SHEBOYGAN

Munoz, Rodrigo A, Sheboygan, to 5131 Garfield St, PO Box 1660, Le Mesa, Calif 92041

WINNEBAGO

Anderson, Gay R, Pompano Beach, Fl, to 111 E North Water St, Neenah 54956

WOOD

Khan, A Hamid, Marshfield, to 604 11th St, New Richmond 54017
Rogers, Charles A, Marshfield, to 4337 Bloomington Ave, Minneapolis, Minn 55407

DEATHS

Knauf, John A, Calumet County, Oct 8, 1977
Weber, Carl J, Sheboygan County, Oct 14, 1977
Adali, Ilhan S, Milwaukee County, Oct 19, 1977
Siebecker, Karl L Jr, Dane County, Oct 19, 1977
Wylde, Robert M, Dane County, Oct 27, 1977
Dundon, John R, Milwaukee County, Nov 8, 1977 ■

OBITUARIES

◈County, State, AMA Members

◈ **Peter Bernard Golden, MD,** 65, Madison, died Sept 3, 1977 in Madison. Born Mar 22, 1912 in Rudyard, Mich, Doctor Golden graduated from the University of Wisconsin Medical School, Madison, in 1940. Doctor Golden served as an associate clinical professor of surgery at the University of Wisconsin, Madison, and retired from active practice in 1965. Surviving is his widow.

◈ **John L Ford, MD,** 72, Green Bay, died Sept 11, 1977 in Green Bay. Born Dec 16, 1904 in Johnstown, Pa, Doctor Ford graduated from the University of Maryland College of Physicians and Surgeons in 1930. Doctor Ford established the pathology department at St Vincent Hospital, Green Bay, and was affiliated with the hospital until his retirement in January 1977. He also served as president of the Brown-Kewaunee-Door County Medical Society in 1951. Surviving are his widow, Gwendolyn; two sons, John L and Daniel, both of Minneapolis, Minn; six daughters, Mrs Patricia Shaw, El Toro, Calif; Mrs Mary Kay Hardcastle, Dayton, Ohio; Mrs Gerry Satterfield, Burnsville, Minn; Mrs Connie Rae White, San Diego, Calif; and Mollie and Colleen, at home.

◈ **Joseph J Adamkiewicz, MD,** 80, Milwaukee surgeon for over 50 years, died Sept 17, 1977 in Milwaukee. Born Mar 10, 1897 in Milwaukee, Doctor Adamkiewicz graduated from Marquette University School of Medicine in 1920. He helped found St Francis Hospital and was the hospital's first chief-of-staff. He also served as a professor at Marquette University School of Medicine. Surviving are his widow, Sylvia; a son, Dr Joseph J, Milwaukee; and two daughters, Mrs Thomas (Donna) Kozina, Franklin, and Mrs John (Marcia) Kircher of Cedarburg.

◈ **Ovid O Meyer, MD,** 76, Madison, internationally known researcher in hematology, died Sept 22, 1977 in Madison. Born Dec 17, 1900 in Stevens Point, Doctor Meyer graduated from Columbia University College of Physicians and Surgeons, New York, in 1926. He joined the University of Wisconsin Medical School faculty in 1932, and from 1945 to 1964 he was chairman of the Department of Medicine. In 1960 he was a consultant in internal medicine to the Surgeon General of the Army. In 1958 Doctor Meyer became a consultant to the Veterans Administration Hospital in Madison and continued in that capacity until January 1976. Doctor Meyer retired from the faculty of the University of Wisconsin in 1971 and the Ovid O Meyer Clinical Scholar Award was established in his honor. Upon his retirement, the State Medical Society of Wisconsin issued a "festschrift" edition of the *Wisconsin Medical Journal* in his honor.

Doctor Meyer will be remembered as a master bedside teacher with peerless clinical judgment and keen diagnostic talents. He'll also be remembered as the physician who always wore a flower in his lapel. Surviving are his widow, Irene; a son, Ralph, Sayre, Pa; and two daughters, Mrs Nancy Godec, Fairfax, Va, and Mrs Mary Rein, Marshfield. Doctor Meyer's first wife, Lyda, died in 1968.

◈ **Otto V Hibma, MD,** 63, Madison, died Oct 7, 1977 in Madison. Born Mar 11, 1914 in Madison, Wis, Doctor Hibma graduated from the University of Wisconsin Medical School in 1939. From 1943-1946 he was an instructor in surgery at the University of Wisconsin. He resigned this position when he went into private practice in 1946 in Madison specializing in surgical diagnosis and general surgery. He continued his affiliation with the University of Wisconsin where he was an associate clinical professor of anatomy teaching surgical anatomy until 1975. He retired from private practice in 1975 where he was associated with Dr Edward Boldon. Surviving are his widow, Barbara; a son, Richard and a daughter, Mrs Richard (Nancy) Kreklow of Madison.

◈ **John Arthur Knauf, MD,** 66, Stockbridge, died Oct 8, 1977 in Crivitz. Born Sept 5, 1911 in Chilton, Wis, Doctor Knauf graduated from Marquette University Medical School in 1935. He was on the medical staff at Calumet Memorial Hospital, Chilton, and an associate staff member at St Elizabeth Hospital in Appleton. Surviving are his widow, Dorothy; two sons, John, Stockbridge and Thomas of Hilbert.

◈ **Karl L Siebecker Jr, MD,** 66, Madison, died Oct 19, 1977 in Madison. Born May 11, 1911 in Madison, Wis, Doctor Siebecker graduated from the University of Wisconsin Medical School, Madison, in 1940. During World War II Doctor Siebecker served in the United States Air Force as a flight surgeon. In 1966 he was president of the Dane County Medical Society. Surviving are his widow, Alice; four daughters, Susan Barnard, Barbara Fillhouer, Robin Siebecker-Kaja of Madison, and Judith Curreri, Dana Point, Calif.; and two sons, Karl L and William of Madison.

◈ **Ilhan Saban Adali, MD,** 48, Greendale, died Oct 19, 1977 in Greendale. Born Oct 19, 1929 in Turkey, Doctor Adali graduated from the University of Istanbul School of Medicine, Turkey, in 1956. He had been a member of the medical staff of the South Milwaukee Clinic, Ltd, since 1970 and also on the medical staff of Mount Sinai Medical Center and Trinity Memorial Hospital. Surviving are his widow, Gerda; a daughter, Lisa, and a son, John, both at home.

◈ **Robert Miller Wylde, MD,** 63, Sedona, Ariz, died Oct 27, 1977 in Phoenix. Born Jan 10, 1914 in Youngstown, Ohio, Doctor Wylde graduated from the University of Kentucky Medical School in 1942. Doctor Wylde practiced in Madison for 30 years as an anesthesiologist and was a founder of Madison Anesthesiologists, SC, before retiring to Sedona in April 1977. Surviving are his widow, Dorothy; and two daughters, Kathryn, Brooklyn, NY and Mrs Monte (Jayne) Perkins of Milwaukee.

◈ **Neal Samuel Simons, MD,** 88, Whitehall, died Nov 2, 1977 in Whitehall. Born Mar 22, 1889 in the Town of Ettrick, Doctor Simons graduated from the University of Illinois Medical School in 1914. A specialist in ophthalmology and otolaryngology, he was one of the founders of the first Whitehall Clinic and Hospital and had served on the hospital's board of directors. In 1971, the new clinic building was dedicated in his honor. He retired from practice in 1967. Surviving are his widow and one daughter, Mrs. James (Elizabeth) Pleier, Milwaukee.

◈ **John R Dundon, MD,** 84, Whitefish Bay, died Nov 8, 1977 in Whitefish Bay. Born July 26, 1893 in Ishpeming, Mich, Doctor Dundon graduated from Rush Medical College, Chicago, Ill, in 1919 and had practiced medicine in the Milwaukee area for 58 years. He was on the medical staff of St Mary's, Columbia, and St. Anthony's hospitals. Surviving are his widow, Loretto; four sons, Peter, Shorewood; James, Whitefish Bay; Thomas, Winston Salem, N Carolina and J Sherman, San Luis Obispo, Calif; and five daughters, Sister Mary Catherine, Milwaukee; Mrs Edward (Elizabeth) Gaffney, Pewaukee; Mrs Charles (Monica) Olsen, Oakland, Calif; Mrs Ronald (Frances) DuPont, Moscow, Idaho, and Mrs. Dennis (Jane) Cummins of St Louis, Mo.

◈ **Rogers E Garrison, MD,** 68, former Wisconsin Rapids physician, died Nov 10, 1977 in Venice, Fla. Born Feb 18, 1909 in Wisconsin Rapids, Doctor Garrison graduated from Northwestern University Medical School in 1932. He served in the United States Army Air Corps during World War II from 1942 - 1946. He had practiced in the South Wood County area from 1935 until his retirement in 1970. Doctor Garrison died from complications resulting in an automobile accident near Bowling Green, Ky, on Nov 1. Doctor Garrison was a member of the International College of Surgeons and the Wisconsin Urological Society. He served as a Councilor of the State Medical Society of Wisconsin from 1953 - 1959 and also served on the Commission on Medical Care Plans during the 1950s. Surviving are his widow, Mace; and two sons, Peter, Atlanta, Ga, and Rogers R of Sparta. ■

NEWS HIGHLIGHTS

Medical Students

. . . are moving towards family practice and primary care, says Assistant Dean Sigurd E Sivertson, MD* of the University of Wisconsin-Madison Medical School. Almost one out of five graduating doctors in 1977 at the UW-Madison went into family practice medicine, and Doctor Sivertson says that's nearly twice as many as a decade or two ago.

Of the 142 graduating doctors in 1977, 27—or 19 percent—selected a family practice residency, according to Medical School figures. Internal medicine was first, at 24 percent, and pediatrics tied for third with 14 percent.

But general internists and pediatricians also spend about 60 percent of their time, Doctor Sivertson says, in "primary care" medicine—defined as that first patient contact plus responsibility for continuing and integrated care. It adds up to about half of 1977's graduating doctors electing primary patient medical care.

"In Wisconsin we have great need for physicians of this type,'" Doctor Sivertson says, but he warns, "Even with more young family doctors, don't look for an old-fashioned GP among them. You won't find one."

While the General Practitioner of yore had an office, a black bag, and a nurse receptionist, Doctor Sivertson says today's counterpart is more likely to be a "family practice specialist" backed up by physician assistants, nurse practitioners, quality care evaluators, new medical techniques, and a "systems approach" to health-care delivery.

Family practice is now a specialty in its own right, he says, and classes in the new specialty teach team medicine, continuing education built into the practice, and office programs to promote and teach health maintenance and illness prevention to patients.

Johnston Municipal Hospital

. . . has terminated operation as a hospital facility, effective January 4, in accordance with action taken by the Common Council of the City of Milwaukee, C Panagis, MD, health commissioner, reported. The hospital, located at 1230 West Grant Street in Milwaukee, has been operated by the Health Department. Termination of hospital services include the emergency medical services. Health Department programs will continue to operate from this facility which has been designated as the Johnston Community Health Center.

Arthritis programs

. . . at the Medical College of Wisconsin (MCW) have been named to receive two grants totalling $33,000 from the Arthritis Foundation. The announcements came from the Foundation's' national office in Atlanta, Georgia.

Robert W Lightfoot, MD, director of the Rheumatic Disease Center at MCW, noted the awards marked the first time a Wisconsin arthritis center will receive National AF funds.

Doctor Lightfoot said a $20,000 grant will be used to upgrade the rheumatology center's clinical treatment and professional training capabilities. The remaining $13,000 grant will support research of Robert H Keller, MD in the MCW department of medicine, who is conducting a study on immune mechanisms in rheumatic disease.

Thomas D Lyons, president of the Wisconsin AF, explained that Wisconsin ranks 37th of 50 states in its number of rheumatologists. "Wisconsin has about 15 trained rheumatologists and we need 40 of them. Hopefully, this investment of Arthritis Foundation funds will not only improve service to people with arthritis, but it will also increase the number of available rheumatologists in the shortest time possible," Mr. Lyons said.

Nationally, the Arthritis Foundation announced 42 center grants totalling $840,000 and 68 research grants totalling $876,500. The Wisconsin AF will allocate about $70,000 to the National AF program in 1977, Mr Lyons said.

The Wisconsin AF is supported primarily through community campaigns, United Funds, and membership dues. ■

PHYSICIAN BRIEFS

Richard G Heidorn, MD
George A Pagels, MD

. . . recently joined the medical staff of the Marshfield Clinic and its satellite clinic in Mosinee. Doctor Heidorn graduated from the University of Colorado School of Medicine and completed an internship at Weld County General Hospital, Greeley, Colo. He joined Boyd Groth, MD,* at the Mosinee Clinic. Doctor Pagels graduated from the University of Illinois School of Medicine and completed his residency in internal medicine at University Hospitals, Cleveland. He is associated with the Department of Internal Medicine at the Marshfield Clinic.

Ben R Lawton, MD*

. . . president of the Marshfield Clinic, has been named to the prestigious Institute of Medicine of the National Academy of Sciences. Doctor Lawton was nominated for the post last year. He is a member of the state Health Planning Council, as well as of the University of Wisconsin Board of Regents.

W W Grover, MD*

. . . Bonduel, recently was elected as president of the Northeastern Wisconsin Health Systems Agency's Board of Directors. He will be at the head of the policy-making body which plans health services in nine Wisconsin counties.

Kulumani M Narasimhan, MD

. . . recently became a member of the medical staff of the Sparta Clinic. He is a graduate of Thanjavur Medical College, India, and served an internship and residency at St Francis General Hospital, Pittsburgh, Pa. He also served a residency at Good Samaritan Hospital, Cincinnati, Ohio. His wife, also an MD, graduated from Calcutta University in India. Prior to joining the Clinic, Doctor Narashimhan had practiced in Hamilton, Ohio.

Mario G Tolentino, MD*
Richard H Strassburger, MD*

. . . Wauwatosa, recently were promoted by the Medical College of Wisconsin. Doctor Tolentino was named an assistant clinical professor of surgery and Doctor Strassburger was named associate clinical professor of neurosurgery.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Edward E Gustavson, MD

. . . Ripon, recently became associated with MDs Robert* and Jean House at the Kemper Clinic. He graduated from Harvard Medical School in 1970, and spent his internship and residency from 1970-73 at the University of Minnesota specializing in pediatrics. He served in the United States Army for two years and also worked on a fellowship in rural family care at the University of North Carolina in Chapel Hill. Prior to joining the Kemper Clinic, Doctor Gustavson had been in private practice in North Wilkesboro, N.C.

John G Jaeger, MD*

. . . Rhinelander, recently became associated with Renolds Saunders, MD as Northwoods Anesthesiologists, Ltd. A graduate of the University of Wisconsin Medical School, Madison, Doctor Jaeger interned at LaCrosse Lutheran Hospital followed by a residency at the Mayo Clinic, Rochester. He spent a year of fellowship in pediatric anesthesiology at The Children's Hospital Medical Center, Boston, Mass. Since his fellowship he has been associated with the Gundersen Clinic, LaCrosse, for the past seven years.

Walter F Smejkal, MD*

. . . Manitowoc, recently was reelected chief of the medical staff for 1977-78 for Holy Family Hospital. The executive committee with Doctor Smejkal includes MDs John A Thranow Jr,* president-elect; Barry V Bast,* secretary-treasurer; Daniel M Pick,* past president; Michael A Jacobi,* Paul L Karrmann,* members-at-large; John R Larsen,* chief of surgery; John D Best,* chief of medicine and Thomas S Arnold,* chief of obstetrics-gynecoloy.

Kenneth Prefontaine, MD

. . . Slinger family practitioner since 1930, recently retired from his medical practice. A graduate from Loyola University School of Medicine, Chicago, Doctor Prefontaine has practiced at Hartford Memorial Hospital since 1930 and at St Joseph Community Hospital, West Bend, since 1940.

Ernest Blondis, MD

. . . Medford, recently became associated with the medical staff of the Medford Clinic. Doctor Blondis, general practitioner from the Chicago area, has practiced medicine for 40 years. Doctor Blondis will work out of the newly reopened Prentice medical facility.

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Joseph Darin, MD*
Charles Aprahamian, MD*

. . . two Medical College of Wisconsin surgeons from Brookfield, recently were presented with a Cine Clinic Plaque at the Clinical Congress of the American College of Surgeons meeting. Doctors Darin and Aprahamian were honored for their teaching film, "Management of Lacerations in the Emergency Room." Doctor Darin is director of emergency medical services at Milwaukee County Medical Complex and Doctor Aprahamian is director of the Institute for Trauma and Emergency Medicine, established jointly by the Medical College and Medical Complex.

David A Van Dyke, MD*

. . . Viroqua, has opened his office for the practice of psychiatry. He graduated from Michigan State University Medical School and completed his residency at Winnebago Mental Health Institute. Doctor Van Dyke also is a consultant for the Douglas Community Mental Health Clinic, Ltd, and the Vernon County Unified Board.

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R G Strong, MD*

. . . Manitowoc, recently retired from his medical practice. A Marquette University School of Medicine graduate, Doctor Strong has practiced medicine for 45 years. He is a grandson of Henry Strong, MD who was president of the State Medical Society of Wisconsin from 1870 - 1871. He was director of the Manitowoc Health Care Center, Manitowoc City Health Commissioner, Deputy Coroner of Manitowoc County, and organized the Alcoholics Anonymous Chapter at Manitowoc in 1947 and serves as its physician. Doctor Strong also is vice-chairman of the Commission of Alcoholism and Drug Addiction of Manitowoc County.

Paul L Schmidt, MD

. . . has joined the medical staff of the Farrell Clinic, Prairie du Chien. He is a graduate of the University of Missouri Medical School and received his specialty training at the University of Wisconsin Department of Family Practice. Doctor Schmidt also is on the medical staff of Memorial Hospital.

David Marcotte, MD
Thomas J Wilson, MD
Richard L Wiesen, MD*

. . . Brookfield, have been appointed to the full-time faculty of the Medical College of Wisconsin. Doctor Marcotte was appointed professor of psychiatry and mental health sciences and director of the Medical College's residency training program. He is a 1963 graduate of Cornell Medical School. Doctors Wilson and Wiesen were appointed assistant professors of psychiatry and mental health sciences. Doctor Wilson is a 1971 graduate of the Medical College of Wisconsin and Doctor Wiesen graduated in 1958.

Helen H Ahn, MD

. . . recently joined the medical practice of Clarence E Kozarek, MD* of Tomah. Doctor Ahn graduated from Ewha Women's University Medical College of Seoul, Korea, in 1966. She served a rotating internship at the Medical Center at Columbus, Georgia and then took her residency training in Clinical Pathology and Nuclear Medicine at the University of Alabama Medical Center in Birmingham.

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Julio C Davila, MD

. . . formerly on the medical staff of Henry Ford Hospital, Detroit, has become associated with the medical staff of Wausau Hospitals. A prominent heart surgeon, he had been surgeon-in-charge for the division of thoracic and cardiac surgery at Henry Ford Hospitals. A graduate from Stanford University School of Medicine, he served his internship and residency at Southern Pacific General Hospital, San Francisco. Doctor Davila also served thoracic surgical residencies at Episcopal Hospital and Presbyterian University of Pennsylvania Medical Center in Philadelphia where he also has held five academic positions.

Doctor Davila designed the widely used hypothermia machine in 1959, the Pemco-Davila heart lung machine in 1961, and the Davila-Sierra artificial mitral valve in 1963.

Sidney K Wynn, MD*

. . . Milwaukee plastic surgeon, presented a motion picture exhibit at the American College of Surgeons Clinical Congress at Dallas in October. His film was entitled "Vomer Flap—Anterior Cleft Palate Surgery."

Terry L Gueldner, MD*

. . . Manitowoc, recently was elected chief-of-staff of Memorial Hospital for 1978. Also elected on the executive committee were MDs Nathan Davis,* vice-president; Cecilio T Mendoza,* secretary-treasurer; Robert Banker,* David Pfaffenbach,* and Edward Barylak,* members-at-large.

Terrence E Peters, MD*

. . . Monroe, has been named city chairman for the 1978 Heart Fund campaign in Monroe. Doctor Peters, a member of the medical staff of The Monroe Clinic, is in charge of the overall management of the activities of the Heart Fund campaign which will be conducted throughout the month of February.

Robert J Gardner, MD

. . . West Bend, recently became associated with Richard D Gibson, MD* in the practice of surgery. He graduated from Northwestern University Medical School aand served his internship and residency training at Northwestern University and West Virginia University Medical School.

J Ernesto Molina, MD

. . . Marshfield, recently became associated with the Marshfield Clinic in the Department of Surgery. Doctor Molina graduated from the University of San Carlos in Guatemala City and served his residency at the University of Minnesota. He also completed a fellowship in cardiac pathology at the university-affiliated Miller Hospital in St Paul. Doctor Molina held an associate professorship of surgery at Texas Tech University, Amarillo, and then became chief of cardiac and thoracic surgery for a consortium of hospitals affiliated with the University of South Florida, Tampa.

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Thomas A Starkey, MD*

. . . Wausau, was elected president of the Wausau Medical Center. He joined the medical staff in 1970 and is a graduate of Northwestern University Medical School. Other officers elected are: MDs, Edgar B Koschmann,* vice-president; and W George Locher,* secretary-treasurer. Doctor Starkey succeeds Kenneth Day, MD,* as president. ■

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1977

1 SMS Commission on Peer Review
2 Subcommittee on Accreditation
2 WisPRO Continuing Medical Education
5 Dane County Medical Society HMP Committee
6 Dane County Medical Society Board of Trustees
7 T-19 Provider Groups
9 SMS Realty Board of Trustees
10 SMS Council
10 WPSIC Members
10 SMS Realty Corporation
12 SMS Publications Review Committee
13 Ad Hoc Committee on Physical Therapy
14 SMS Commission on Governmental Affairs
14 SMS Committee on Environmental Health
14 SMS Committee on Federal Legislation
14 Ad Hoc Committee on Brain Death
14 SMS Commission on Mediation and Professional Ethics
15 WisPRO District Review Committee
15 WisPRO Review Evaluation Committee
15 Uniform Claim Form
15 Task Force on Health Screening and Immunization
16 SMS Physicians Alliance Commission
16 SMS Committee on Maternal and Child Health
16 SMS Medical Defense Committee
16 SMS Maternal Mortality Study Committee
16 SMS Publications Review Committee
16 SMS Physicians Alliance Commission Reception Honoring Christopher Cohen newly appointed Principal Regional Official of the US Department of Health, Education, and Welfare for the Midwest
20 SMS Committee on Evaluation of Delivery and Cost of Medical Care
21 Health Care Coalition

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

WPS

report

for Wisconsin Physicians

Volume VII, Number 1

January 1978

COORDINATION OF BENEFITS

Occasionally you may find that one of your patients is eligible for benefits through two group health insurance plans. Today it's not uncommon for both the husband and wife to work. In many cases, both will elect to enroll in the group health insurance plan offered by their employer. They may both, therefore, be eligible for payment of health care costs by both companies.

An insurance company is obligated to pay for health care expenses, subject to the terms of their subscriber's contract. If these payments exceed actual costs because two or more policies are in effect, inflation of health care costs is increased. We are all aware that costs of health care and of health insurance are rising faster than anyone really likes. We are all interested in fighting inflation that threatens access to health care services and distorts utilization.

WPS and other insurance companies use a variety of methods to ensure that the payments they make are fair, reasonable and accurate. One of these methods is called Coordination of Benefits.

Coordination of Benefits divides, in an equitable fashion, the costs to be paid by the two insurance companies. In this way, the patients' health care costs are paid up to the maximum allowable amount.

A special section of WPS' Claims Division collects information and examines claims to determine whether such cost-saving actions can be taken. Although this may at times necessarily delay resolution of a particular claim, the program's cost containment benefits are well documented.

WPS feels that its Coordination of Benefits activity is important not just to the patient, but to you, the physician, as well. If anyone "profits" inequitably on health insurance, insurance premiums become more costly for subscribers and employers alike, and your efforts and ours to slow the rising costs of health care becomes that much more difficult.

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COMMON MEDICAL ELEMENTS

Medical terminology is made up of elements or roots from Latin and Greek. In order to know what the medical term means, you have to know what the elements mean. The elements listed below are among the most common in medical terminology you will encounter as a medical assistant. Knowing their definitions will help you with the terminology.

ALPHABETICAL LIST OF 83 ELEMENTS

an, a	without, not
anti	against
arthr	joint
benign	mild, not cancerous
bi	two, double
cele	hernia
centesis	puncture, aspirate
cephal	head
cervic	neck
crani	skull
cryo	cold, application of cold
cyst	bladder, sac containing fluid
dermat	skin
desis	binding, fixation
ectomy	surgical removal, all or part
enter	intestines (usually small)
esthesia	sensation
gastr	stomach
gingiv	gum
gravid	pregnancy
hemi	half
hepat	liver
hyper	above, more than normal
hypo	under, beneath, deficient
hyster	womb, uterus
iasis	condition of, presence of
ile	ileum, (intestines)
ili	ilium, (hip)
infra	beneath
inter	between
intra	within
itis	inflammation
lapar	abdominal wall
leuk	white
lith	stone
malign	bad, cancerous
metabole	change
myel	narrow, spinal column, spinal cord
myring	ear drum
oma	tumor
onco	mass, tumor
onych	nail
oophor	ovary
osis	condition of
ost	bone
ostomy	to create a new opening
otomy	incision into
part	labor, bring forth
peri	about, around
pexy	suspension, fixation
phleb	vein
plast	plastic repair, surgical repair
pleura	rib, side
post	after, following
pre	in front of, before
pro	in front of, before
proct	anus
ren	kidney
rhin	nose
rrhaphy	suture
salpingo	fallopian tubes
scirr	hard
sclera	hard
sedat	quiet, calm
spasm	involuntary contractions
squam	scale, scaly texture
steno	narrow contracted
therap	therapy
therm	heat
thromb	clot, lump
thyro	thyroid
trachel	neck
traumat	wound
tri	three
trip	rub, friction
tumor	swelling
tympan	ear drum
ureter	tube from kidney to bladder
urethra	tube from bladder to outside
utero	uterus
umbilic	navel
vena	vein
vesic	bladder

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GREEN BAY, WISCONSIN—AN excellent opportunity is available for a family practice physician in the Green Bay, Wisconsin area. A younger family practice resident, or general practitioner with some experience is desired. New office setting is in close proximity of a family practice oriented hospital facility. Association and practice arrangements flexible. Contact: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. 1-2/78

AVIATION AND NUCLEAR MEDIcine—Other specialties also needed, $33,500 or higher starting salary based on qualifications and experience, plus noncontributory retirement plan, malpractice insurance paid, and full healthcare benefits. East and West coast locations. Please write to L G Tenneson, NRD, 611 N Broadway, Milwaukee, Wis 53202. 1-12/78

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WANTED: FAMILY OR GENERAL practitioner to join 3 physicians serving East Central Wisconsin small college town of 7,000, close proximity to community hospital with up-to-date facilities. Guaranteed base income with opportunity for partnership. Call or write for details to R S Pelton, MD, 315 Mt Zion Dr, Ripon, Wis 54971. Tel: 414/748-2875. 1tfn/78

GREEN BAY. OPPORTUNITY FOR a primary care internist or family physician to join a 3-man group. Full partnership available second year. Contact: John Brusky, MD, 1203 S Military Ave, Green Bay, Wis 54304. Tel: 414/494-4781. 1tfn/78

MEDICAL FACILITIES

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77 ■

NEW MEDICAL-DENTAL OFfices for lease: Opportunity to plan and design your new office. Designs for offices 650 to 4000 square feet. Spacious, modern facility now available in convenient Hales Corners. For appointment call 414/271-5017. p12/77,1-2/78

WAUWATOSA OFFICE OF RETIRing GP immediately available. Three examining rooms, consultation, treatment and waiting room. Excellent opportunity to take over established active practice, or specialize; purchase equipment and employ present receptionist. $250 per month includes heat, light, air conditioning, and adjacent 20-car free parking. Log Cabin Medical Center, 2515 Wauwatosa Ave., 52313. Tel: 414/774-1121. 1tfn/78*

FOR SALE: OFFICE AND MEDIcal equipment of deceased doctor who was engaged in general practice and surgery in the Village of Waterford, Racine County, Wis. Call: 414/539-2868. gltfn/78

FOR RENT: OFFICE SPACE USED by general practitioner prior to his death in the Village of Waterford, Racine County, Wis. Call: 414/539-2868. gltfn/78

FOR LEASE: 4611 N OAKLAND Ave, Milwaukee, (Whitefish Bay-Shorewood). 2400 square feet first floor with entrance ramp, custom built for physician's office. Many extra features, carpeting, drapes, view boxes, dictaphone system, two lavatories, central air conditioning. Call: 414/964-8670, evenings 414/962-6376. 1-2/78

OFFICE SPACE AVAILABLE: New professional building—West Bend, Wis. 30 miles north of Milwaukee. Located directly across from only hospital in area. Individual offices presently occupied by two orthopedic surgeons, one ophthalmologist, one OB/GYN, one family practice group (4 MDs), three dentists, and pharmacy. Two suites available—1200 sq ft and 800 sq ft. Will develop to your requirements. Ideal for any medical specialty—internist, surgeon, dermatologist, urologist, pediatrician, etc. Write or call: Management Committee, Oakbrook Medical Complex, 1201 Oak St, West Bend, Wis 53095. % R. H. Schacht, DDS, 414/334-5151. 12/77,1/78*

MISCELLANEOUS

WOULD LIKE PART-TIME RECEPtionist-secretarial work in physician's office. Madison-Middleton area. Previous experience. Phone 608/831-7595, Madison. 1/78

GET WARM THIS WINTER ON Grand Cayman in British West Indies. Comfortable two-bedroom plus sleeping porch on beach overlooking sea and surf. Everything furnished. (Not available, 12-16-77 to 1-20-78). $200 week. Write Box 44, Boddentown, Grand Cayman, BWI. 12/77,1/78 ■

CONTINUING MEDICAL EDUCATION
MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 Wisconsin

Feb 14-16: *Fifteenth Annual Telemark Symposium and Ski Outing.* Sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians at Mount Telemark, Cable, Wis. Six hours of CME credit, and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Feb 15: *In-Depth Teaching Program,* Methodist Hospital, Madison.

Mar 1-Apr 5: *Recent Advances in Internal Medicine for the Practicing Clinician; Series 6: Infectious Disease,* Medical College of Wisconsin, Milwaukee.

Mar 16: *In-Depth Teaching Program,* UW Center for Health Sciences, Madison.

Mar 29-Apr 5: *Gynecological Pathology, Cytogenetics, Endocrinology,* Medical College of Wisconsin, Milwaukee.

Mar 30-Apr 1: Second Annual *Ophthalmology Current Concepts Seminar '78* of the University of Wisconsin-Madison. Lectures and workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison; at The Wisconsin Center, Madison. Info: Mrs Margaret Kelm, UW Hospitals, 1300 University Ave, Madison, Wis 53706.

Apr 1: Tenth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee, Wis. See details in box elsewhere in this issue.

Apr 6-27: *Diabetes* lectures around the state.

Apr 13-15: SMS Annual Meeting, MECCA, Milwaukee. Headquarters Hotel: Marc Plaza.

Apr 28: *Pediatric Anesthesia,* LaCrosse.

Apr 28-29: *Wisconsin Psychiatric Association Annual Scientific Meeting,* at Marshfield Clinic, Marshfield. Friday program: Medical and Psychiatric Utilization of Services. Saturday: Behavorial Change From Four Viewpoints. 10 hours of Category I CEC.

May: Spring Meeting, Wisconsin Neurological Society.

May 12: *Perinatal Medicine,* LaCrosse.

May 11-13: *Heart Disease and Rehabilitation: State of the Art 1978* at Marc Plaza Hotel, Milwaukee. Sponsored by Cardiovascular Disease Section of Mt Sinai Medical Center, Wisconsin Heart Association and University of Wisconsin, Milwaukee. Info: Carl Foster, PhD, Dept of Medicine, Cardiovascular Disease Section, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201.

May 19-20: *Emergency Problems in Pediatrics,* UW-Madison.

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1978 NEIGHBORING

Feb 21-23: CME Course: *Approaches to Clinical Problems in Gastroenterology and Hepatology,* sponsored by University of Chicago Section of Gastroenterology and Liver Study Unit. At Center for Continuing Education, Chicago. Approved for 22 hours of Category I credit for AMA-PRA. Info: Sumner C Kraft, MD, Course Director, 950 E 59th St, Chicago, Ill 60637. 12/77, 1/78

Feb 25: *Conference on Colon-Rectal Cancer,* Red Wing Area Technical Institute, Red Wing, Minn. Details in box elsewhere in this issue.

Mar 29-31: *Diagnostic and Therapeutic Advances in Gastroenterology,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Apr 7: *Pediatric Challenges,* the sixth annual symposium for primary care physicians, at Minneapolis Children's Health Center, 2525 Chicago Avenue, Minneapolis, Minn 55404 (612/874-6122). Presentations: Adolescent Depression, Early Recognition of Melanoma, Constipation and Soiling, Treatment of Croup, Unexpected Problems at Delivery, and Behavorial Milestones in the Preschool Child. Recognized for six prescribed credits by the American Academy of Family Physicians. g1-3/78

Apr 12-14: *Laboratory Medicine,* American College of Physicians Postgraduate Course, Mayo Clinic and Mayo Foundation, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

May 9-10: *Aging-1978: Political and Economic Realities,* fifth annual series of interdisciplinary conferences for the professional community serving the aging, by the Illinois Association of Homes for the Aging, at Pick Congress Hotel in Chicago. Speakers include nationally recognized authorities in the field of aging, with outstanding expertise and the known capability of getting their message across to a highly diversified professional audience. Geared to all those who work with the aging, including government agency personnel, students, volunteers, staff members of social and community service agencies, physicians, long-term care administrators, housing managers, and the like. Info: Conference Coordinator, IAHA Institute on Aging, 3300 W Peterson Ave, Chicago, Ill 60659; 312/583-9850. g1-4/78

41st Annual
New Orleans Graduate Medical Assembly

March 31 - April 4, 1978

Meeting Theme:
The High Risk Patient

Accreditation:
AMA-Category I/AAFP, ACEP

Program Director:
Oliver H Dabazies Jr, MD FACS

Fee: $200 nonmember physicians. Military: $100. Students, residents, interns and fellows: complimentary registration.

Write or phone:
New Orleans Graduate Medical Assembly, Room 1538 Tulane Medical Center, 1430 Tulane Ave, New Orleans, La 70112; 504/525-9930. 11-12/77, 1-2/78

May 10-12: *Nuclear Medicine for the Internist,* American College of Physicians Postgraduate Course, Mayo Clinic and Mayo Foundation, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

May 14-16: Eighth annual meeting, Great Plains Organization for Perinatal Health Care, Radisson South Hotel, Bloomington, Minn. Further details appear elsewhere in this section.

May 22-24: *Multidisciplinary Management of Solid Tumors,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: ACP, 4200 Pine St, Philadelphia, Pa 19104.

May 22-24: *Hematology Update 1978,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

1978 Others

Jun 14-18: *Third Annual Symposium on Lung Disease,* at The Cloister, Sea Island, Georgia. A symposium on the diagnosis and management of lung disease for practicing physicians. Info: Betty Rafshoon, Georgia Lung Association, 1383 Spring Street NW, Atlanta, Ga 30309; 404/876-3601. g1-5/78

University of Wisconsin-Madison
Center for Health Sciences

Department of Continuing Medical Education and UW-Extension

CME Calendar—1978

Feb. 8: *Nurse/Physician Team Program,* St Marys Hospital Medical Center, Madison.

Feb 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Mar 14: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11: *Dane County Computerized Tomography Meeting,* The Wisconsin Center, Madison.

Apr 11-12: *Patient Education,* The Concourse Hotel, Madison.

Apr 13-15: *Seminar-Workshop in Radiology,* The Wisconsin Center, Madison.

Apr 21-22: *Conference on Dermatology,* The Wisconsin Center, Madison.

Info: Coordinator, Dept of CME, 601 Walnut Street, Madison, Wis 53706; phone: 608/263-2850.

Jan 30-Feb 3: Annual Scientific Assembly of American Society of Contemporary Medicine and Surgery, at Americana Hotel in Miami Beach, Fla. Meets criteria for 40 hours of credit in Category I for AMA-PRA. Info: John G Bellows, MD, PhD, Director, 6 North Michigan Ave, Chicago, Ill 60602; (312) 236-4673. g8-12/77

Feb 24-25: *Fourth Annual International Symposium on Psychopharmacology—Depression.* Registration Fee: $60.00. Eleven hours Category I credit and 11 prescribed credit hours—AAFP. Contact: Herman C B Denber, MD, University of Louisville School of Medicine, Health Sciences Center, Louisville, Ky 40232. 1-2/78

Mar 6-17: Mediclinics Postgraduate Medical Refresher Course, Fort Lauderdale, Fla. 50 Hours credit AAFP. Info: Mediclinics, 832 Central Medical Bldg, St Paul, Minn 55104.

Apr 1-6: *American College of Allergists 34th Annual Congress,* at Las Vegas Hilton Hotel, Las Vegas, Nev. Comprehensive review of clinical immunologic and allergic diseases relevant to the needs of the physician in practice. The 5.5-day program will focus on physician/registrant participation. Credit: AMA CME Category I—30 hours. Registration fee: Members—$75, nonmembers—$190. No fee for Residents, Interns, Nurses and Technicians from teaching hospitals presenting letters from department heads. Info: Frances P White, Executive Secretary and Treasurer, American College of Allergists, 2141 Fourteenth St, Boulder, Colo 80302; 303/447-8111. g1-2/78

Conference on
Colon-Rectal Cancer

Red Wing Area Technical Institute, *Red Wing, Minn*

Saturday, Feb, 25, 1978

Program from 9 am to 3:45 pm

- *Introduction and Overview of Critical Management Issues,* Hugh L Davis, MD, UW-Madison Center for Health Sciences, Madison, Wis
- *Early Diagnosis — Our Best Weapon Screening Physical Examination Endoscopy, CEA,* James E VanderMeer, MD, Dean Clinic, Madison, Wis
- *Roentgen Diagnosis of Colon-Rectal Lesions,* Harley C Carlson, MD, Mayo Clinic, Rochester, Minn
- *Surgical Therapy of Colon-Rectal Cancer,* Theodore B Grage, MD, University of Minnesota
- *Panel,* above participants
- *The Role of Radiation Therapy,* Robert H Greenlaw, MD, Marshfield Clinic, Marshfield, Wis
- *Combined Modality Treatment: Adjuvant Therapy—The Medical Oncologist's View,* Hugh L Davis, MD
- *Combined Modality Treatment: A Surgeon's View of Adjuvant Therapy,* Theodore B Grage, MD
- *Paliative Management of Advanced Disease,* Hugh L Davis, MD
- *Panel,* all participants

Further info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

Eighth Annual Meeting

GREAT PLAINS ORGANIZATION FOR PERINATAL HEALTH CARE

Perinatal Care from Community to Center

Sunday-Tuesday, May 14-16, 1978

Radisson South Hotel
Bloomington, Minnesota

Guest Speakers:
Dr Thomas G Baffes—*Perinatal Malpractice from Community to Center*

Dr William J R Daily—*Who Is the Normal Newborn?*

Dr Gregory Grabowski—*Perinatal Genetics for Who and Why?*

Dr Frank Boehm—*Expected Date of Confinement*

Each plenary speaker will present a workshop and the other 18 workshops or panel discussions are planned around both obstetric and neonatal care aspects of perinatal care. Continuing Education credits/cognates have been applied for.

* * *

The Great Plains Organization is composed of nurses, physicians, administrators, social workers, and other professionals interested in improving perinatal care in the six upper midwest states (North and South Dakota, Minnesota, Wisconsin, Iowa, and Nebraska). The Organization is unique in its broad regional approach and perinatal interdisciplinary involvement. GPO's aim is to foster the development and implementation of programs to enhance health care to pregnant women and newborn infants as well as promoting total family involvement in the perinatal process.

* * *

For further information contact Mrs Virginia Rittenour, Coordinator, Great Plains Organization, 420 Delaware St SE, Box 50, Minneapolis, Minn 55455; (612) 373-5718.

1978 OTHERS

May 19-21: *Medicine of the Whole Person,* sponsored by American Holistic Medicine Association; cosponsored by Biogenic Institutes of America and American Society of Contemporary Medicine and Surgery, at Denver, Colo. Biogenic Institutes of America, Inc (a not-for-profit foundation dedicated to health) certifies that this continuing medical education offering meets the criteria for 9 credit hours in Category I of the AMA Physician's Recognition Award. Contact Biogenic Institutes of America, Inc, Route 2, Welsh Coulee, La-Crosse, Wis 54601; 608/786-0611. g1-4/78

May 22-26: *Review of the Old and New in the Diagnosis of Infectious Diseases,* American College of Physicians Postgraduate Course, Alton Ochsner Medical Foundation, New Orleans, La. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Oct 17-21: *Medical Knowledge Self-Assessment Program Course,* Hyatt Regency, New Orleans, La. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

1978 AMA

Mar 31-Apr 1: *Regional drug abuse conference: The Physician and Drug Abuse Treatment,* by AMA's Dept of Mental Health, at Water Tower Hyatt Hotel, Chicago. For physicians in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Registration fee: $50—AMA members, medical society executives, nonphysicians; $100—nonmember physicians; special reduced rates for housestaff and medical students. Category I credit for the AMA-PRA will be given on an hour-for-hour basis. Program: Welcoming remarks by Joseph H Skom, MD, chairman. • Medical Involvement in Drug Abuse. • Attitudinal Barriers: The Physician's, the Patient's, Other Health Personnel. • The Current Drug Scene—The State of Abuse. • Six each Concurrent Workshops and Clinical Seminars: (1) Making Effec-

Tenth Annual Southeastern Wisconsin Cancer Conference

COLON CANCER

April 1, 1978

Pfister Hotel—Milwaukee Wisconsin

8:00-9:00 am Registration

9:00-9:30 am Harlan J Spjut, MD, Professor of Pathology, Baylor Head of Anatomic Pathology, St Luke's Hospital, Houston, Tex

9:30-10:00 am Frances J Tedesco, MD, Co-Director of Clinical Research Unit, University of Miami, School of Medicine, Miami, Florida

10:00-10:30 am LaSalle LeFall, MD, Professor and Chairman, Department of Surgery, College of Medicine, Washington, D C, Howard University

10:30-11:00 am Coffee

11:00-11:30 am Leonard L Gunderson, MD, Assistant Professor in Radiation Oncology, Massachusetts General Hospital and Harvard Medical School

11:30-12:00 n Reginald Pugh, MD, Head of Division of Medical Oncology, Alleghany General Hospital, Pittsburgh, Pa

12:00-12:30 pm Panel Discussion Moderator: John J Gramling, MD, Associate Clinical Professor of Surgery, Medical College of Surgery, Medical College of Wisconsin

Credit: 3 Hours of Category I AMA-PRA, also 3 Hours of elective credit by AAFP

Conference Chairman: *Frank E Berridge, MD,* 8430 West Capitol Drive, Milwaukee, Wis 53222.

1978 Madison
In-Depth Teaching Programs

Preliminary Schedule

Jan 19, 1978—(Thursday) St Marys Hospital Medical Center

Feb 15, 1978—(Wednesday) Methodist Hospital

Mar 16, 1978—(Thursday) University Hospitals—(changed from Nov 17, 1977)

University of Wisconsin Medical School-Madison

Department of Ophthalmology Faculty 2nd Annual

OPHTHALMOLOGY CURRENT CONCEPTS SEMINAR "78"

March 30-April 1, 1978

Wisconsin Center, 702 Langdon St, Madison

Lectures and Workshops

- The Swollen Optic Disc with Workshop on Representative Case Histories
- New Therapeutic Modalities in Glaucoma
- Diagnosis and Management of the Narrow-Angled Eye
- Surgical Treatment of Glaucoma
- Ocular Torsion
- Strabismus Surgery Advances
- DCR Technique
- Oculoplastic Potpourri
- Anterior Segment Surgery with Infusion Aspiration Cutters and Emulsifiers
- Recent Correlates of Ocular Physiology and Fluorescein Angiogram and Angioscopy
- Restoring Vision in Aphakia; Spectacles, Contact Lens or Implant? With Workshop on Case Presentations
- Diagnosis and Treatment—Macular Disease
- Extramacular Kuhnt-Junius
- Clinicopathologic Correlation of Photocoagulation Lesions
- Application of DRS Findings to the Management of Patients with Diabetic Retinopathy
- Diabetic Retinopathy Vitrectomy Study Progress Report
- Ocular Herpes Simplex—Problems in Diagnosis and Treatment
- Underdiagnosed Imitators of Macular Disease
- Diabetic Macular Disease—Differential Diagnosis and Management
- Fluorescein Angiography — Basic Clinical Concepts
- Radiologic Techniques for Orbital Fractures
- Ultrasound
- ERG-VER Testing in Pediatric Ophthalmology
- Bacterial Corneal Ulcers in Cosmetic Soft Contact Lens Wearers
- Diagnosis and Management of Keratoconus

Participating Faculty

Richard Appen, MD
George Bresnick, MD
Frederick Brightbill, MD
Suresh Chandra, MD
Matthew Davis, MD
Guillermo de Venecia, MD
Richard Dortzbach, MD
Terry Ernest, MD
Thomas France, MD
Paul Kaufman, MD
Burton Kushner, MD
Frank Myers, MD
Harry Roth, MD
Thomas Stevens, MD
Rodney Sturm, MD
Ingolf Wallow, MD

Guest Faculty

Jay H Krachmer, MD, University Hospitals, Iowa City, Iowa

Info: Mrs Margaret Kelm, University Hospitals, 1300 University Ave, Madison, Wis 53706

tive Referrals, (2) Relating to Law Enforcement, (3) Improving Prescribing Practices, (4) Working with Non-MD Personnel, (5) Dealing with Polydrug Abuse, and (6) Office-based Treatment; and (1) Adolescent Care, (2) Geriatric Problems, (3) Perinatal Care and Problems, (4) Emergency Room Problems, (5) Psychiatry and Drug Abuse, and (6) The Drug Abuser as a Surgical Patient. • Informal discussion groups: (1) Medical School Education—Career Teachers, (2) Therapeutic Communities, (3) Self-help Groups, (4) Methadone Maintenance, (5) Industrial Programs and (6) Impaired Physician Programs. • Reports from the workshops. • Concurrent State Sessions (Putting conference recommendations to work on the local level; working with single state agencies). g1-2/78

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

January 23-February 5

New Thoughts About Older Patients, with Manuel Rodstein, MD, Chief of Medical Services and Director of Cardiology, and Elias Savitsky, MD, Director of Psychiatry, Kingsbridge Center both at Jewish Home and Hospital for the Aged, New York, New York, A clinically oriented three-part telecourse on patient care for the elderly. One hour AMA Category I, AAFP prescribed credit.

February 6-February 19

Urinary Infections in the Adult Woman, with Anthony Schaeffer, MD, Assistant Professor Urology, Northwestern University Medical School, Chicago.

February 20-March 5

Ophthalmology in Clinical Context, with John W Chandler, MD, Clinical Associate Professor of Ophthalmology, University of Washington, School of Medicine and ophthalmologist, Swedish Hospital Medical Center, Seattle. One hour AMA Category I, AAFP prescribed credit.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1978 Meeting Dates/Sites

Apr 24-26: American Academy of Neurology, Los Angeles.

Apr 23-27: American Association of Neurological Surgeons, New Orleans.

Sep 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

Mar 13-16: Spring Meeting, American College of Surgeons, Cincinnati.

CLEANING, DISINFECTION AND MAINTENANCE OF ENDOSCOPES

GI Assistants course sponsored by the Section of Gastroenterology The Medical College of Wisconsin

February 3, 1978, Milwaukee, Wis

This seminar will deal with the prevalence and prevention of infectious diseases in the endoscopy unit, cleaning and basic maintenance of endoscopes and endoscopic equipment.

Participating in the presentations and discussions will be a microbacteriologist, an epidemiologist, endoscopy nurses and representatives of instrument and pharmaceutical companies.

This course is being held in conjunction with the 6th Annual Endoscopy Conference for Physicians, sponsored by the Medical College of Wisconsin, February 1-4, 1978.

Registration fee: $75

Info: Ms Marcis Pfeifer, RN, Course Director, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406

CONTRIBUTIONS—CES FOUNDATION
November 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1977.

Unrestricted

Henry A Anderson, MD; GP Langenfeld, MD; MF Huth, MD; David J Carlson, MD; John V Berger Jr, MD; John S Honish, MD; Donald M Ruch, MD; Gamber F Tegtmeyer Sr, MD; John A Booher, MD; Chetek Community Fund; Gerald J Biedlingmaier, MD; CJ Buscaglia, MD; Edward W Vetter, MD; JC Griffith, MD; EJ Nordby, MD; Alan W Babcock, MD; Lon D Babbitt, MD; CW Osgood, MD; KA Qasem, MD; Ralph C Frank, MD; Raymond L Hansen, MD; Donald W Schulz, MD; Roy B Larsen, MD; Frank J Scheible, MD; Werner Langheim, MD; John S Harris, MD; Howard F Schloemer, MD; LT Schlenker, MD; AE McMahon, MD; Derward Lepley Jr, MD; James E Robinson, MD; Dr-Mrs William W Chandler; Otto K Stewart, MD; RS Cron, MD; Morton Josephson, MD; Dr-Mrs David L Sovine, MD; Kenneth L Matson, MD; Anthony S Grahek, MD; Maurice L Whalen, MD; LR Pfeiffer, MD; Peter Lameka Jr, MD; Waldemar W Wolfmeyer, MD; Paul O Simenstad, MD; Curt G Grauer, MD; Richard C Wixon, MD; George H Vogt, MD; Jack D Heiden, MD—*Voluntary Contributions*

Restricted

Dr-Mrs Herbert F Sandmire, MD—*Brown County Loan Fund*
Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs Robert T Schmidt—*Mr Carl W Kouba; Mrs Ione Brown (Brown County Loan Fund)*
Dave and LaVonne Beale—*Jane Robson*
Dane County Medical Society—*Peter B Golden, MD; Ovid O Meyer, MD*
Mr-Mrs Earl R Thayer—*Peter B Golden, MD; Ovid O Meyer, MD; OV Hibma, MD; RE Garrison, MD; Mr Harold Wruck; Karl Siebecker, Jr, MD; John L Ford, MD; JJ Adamkiewicz, MD*
Donald P Davis, MD—*Forrester Raine, MD*
Mrs Robert W Burns—*Frank A Noonen; Harry Conlon; John Ford, MD*
Dorothy M Wylde and Friends—*Robert M Wylde, MD*
Dr-Mrs George F Meisinger—*Mr William Laird*

CASH ADVANCES AVAILABLE TO MEDICAID PROVIDERS

The State Department of Health and Social Services (DHSS) has announced that all Wisconsin Medicaid providers may obtain an 80 percent cash advance on all backlogged pre-July 1, 1977 Medicaid claims. DHSS has said it now realizes that it will take six to nine months at least to unsnarl the claims left unpaid by previous carriers. The details of the cash advance procedure are contained in a Medicaid Status Report mailed to all Medicaid providers in late December. Providers should not confuse this cash advance with a settlement of claims. By accepting this 80 percent cash advance some providers may have to return a portion of the money in the event of some claims being denied for example, due to patient ineligibility. Providers who wish to obtain a cash advance should complete the form found in Attachment A of the Medicaid Status Report and return it to: CASH ADVANCE REQUESTS, Bureau of Health Care Financing, Room 325, 1 West Wilson Street, Madison, Wisconsin 53702. Providers should allow a minimum of three weeks for the processing of the applications.

REVISED OCCUPATIONAL HEALTH GUIDE AVAILABLE

A newly revised and updated "Occupational Health Guide for Medical and Nursing Personnel" is now available to all physicians and nurses in the commercial and industrial setting. It was prepared by the Society's Occupational Health Committee and the Occupational Health Nurses Section of the Wisconsin Nurses Association, in consultation with the Wisconsin Division of Health. The Guide is concerned with the scope and objectives of occupational health programs and, in particular, the functions and relations of physicians and nurses in this health field. Cost of the Guide is $11 with 3-ring binder and $10 without binder. To order copies, send request and payment to the Committee on Occupational Health, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

DHSS HAS NEW BUREAU OF PREVENTION

With the recent reorganization of the DHSS, a new Bureau of Prevention was created within the State Division of Health. The basic charge of the Bureau is to pursue programs which will aid both the public and private sectors in the prevention and containment of chronic and communicable diseases. A listing of the existing programs and key staff in the Bureau of Prevention will appear in the next Bluebook Update section.

WHERE TO SEND CATEGORY I CREDIT DOCUMENTATION FOR RE-LICENSURE

Physicians are reminded to send their documentation of Category I credit for fulfilling the State's requirements for re-licensure in 1980 to: Wisconsin Medical Examining Board, 1400 East Washington Avenue, Madison, Wisconsin 53703. The MEB requires 45 hours of Category I Continuing Medical Education to be accumulated between January 1, 1977 and December 31, 1979 for renewal of the 1980 license. Category I credit towards the AMA Physicians Recognition Award can be used as well as other Category I CME credits such as the American Academy of Family Physicians. *Physicians are not to send this documentation to SMS!*

MASSIVE VITAMIN DOSES POSE HEALTH PROBLEMS

Massive overdose of vitamins is on the verge of becoming a major health problem in the United States. The American Medical Association's director of foods and nutrition warned physicians to be alert for many more cases of vitamin overdose poisonings, in the wake of legislation and court rulings that have virtually wiped out the few remaining controls over vitamins in the United States. "The lid is off," declared Dr Philip White in an editorial in the *JAMA*. "Who now is to protect the consumer from the health food entreprenuer?" ■

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Socety.

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice." ■

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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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STATE SUPREME COURT UPHOLDS STATE MALPRACTICE PLAN

On a 4-3 vote, the Wisconsin Supreme Court January 3, 1978 said the state malpractice panel system created by the Wisconsin Legislature in 1975 was constitutional in virtually all aspects. The court said the plan did not deny fundamental rights because the right to access to the courts with jury trials was "expressly preserved." The Court considered a series of questions in the case, which was brought against the Administrator of Courts by a number of petitioners. Among the questions considered was whether or not the malpractice panel system violated the principle of equal protection of law; granted an unlawful delegation of judicial authority to patients' compensation panels; and allowed the appointment of formal panels of five or six members.

The majority of the justices upheld the panels provisions on all constitutional counts, and determined that the Legislature had intended that formal panels have five members, not six. In upholding the constitutionality of the law, the court also stated that, contrary to charges contained in the challenge, medical malpractice actions "are substantially distinct from other tort actions" and that there was a rational basis for the actions of the 1975 Legislature.

One of the key arguments of the challenge was that the panel system was inherently unfair in that panel members representing physicians or other health-care providers would deny victims "an impartial tribunal" without due process. The Court rejected this notion, stating that the "argument appears to be based upon the presumption that all health-care providers are prejudiced. We know of no rule of law or constitutional interpretation to support such a proposition."

The high court specifically deferred a ruling on the "cap" on awards which is provided in the law. The judges said since there was no way that this statutory provision could affect the petitioners in this case, "we deem it judicially inappropriate to now express judgment on the prospective application of this state statute."

Voting to uphold the law's constitutionality were Judges Connor T Hansen, Robert Hansen, Leo Hanley, and Chief Justice Bruce Beilfuss; dissenting were Justices Roland Day, Nathan Heffernan, and Shirley Abrahamson.

CARTER SIGNS REIMBURSEMENT BILL

The Rural Health Clinic Services bill (HR 8422) which authorizes Medicare and Medicaid reimbursement for services performed by physician extenders (physician assistants and nurse practitioners) was signed into law as PL 95-210. The bill allows reimbursement for services performed by physician extenders which are incident to a physician whether or not the physician is present or the service is performed in the facility of the physician. It also provides reimbursements for physician extender services that are normally performed by a physician. The State Medical Society's Committee on Federal Legislation was opposed to the bill, since it is felt that reimbursement should be made directly to the supervising physician rather than directing payment to the rural health clinic and secondly, the physician extender must be supervised.

REGIONAL DRUG ABUSE CONFERENCE SLATED

The American Medical Association's Dept. of Mental Health is sponsoring a conference on "The Physician and Drug Abuse Treatment" for physicians in the midwest region on March 31-April 1, 1978. Registration fees are $50 for AMA members and $100 for nonmembers. Category I credit for the AMA Physician's Recognition Award will be given on an hour for hour basis. Interested physicians should contact Emanuel M. Steindler, Director, Dept. of Mental Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, 312/751-6000. ▪

It takes more than a veto

THE SENATE'S ACTION in sustaining Acting Governor Schreiber's veto of the chiropractic bill is encouraging, but those who have watched the chiropractors political tactics over the years know that they will be back next year, and the next year, and the next, each time gaining a little more until their fatigued opposition finally gives in.

All sorts of reasons have been advanced in attempting to explain the chiropractors' success in the legislative arena, and most make sense. Sure they possess dogged persistence, sure they are generous with their campaign contributions, sure they have an effective lobby, and sure they persuade their grateful patients to go to bat for them with written testimonials —but those factors don't account for their ability to gain ground year after year in spite of the absolute worthlessness of their "science." The public knows that no chiropractor has ever made a discovery or developed a treatment of importance in the care of the sick. But they go to chiropractors in surprising numbers anyway—why?

The answer is no secret. They go because their doctors haven't satisfied them. Very few patients go to a chiropractor first if they believe there's anything really wrong. They wind up in a chiropractor's office by default or out of frustration. All of the chiropractor's pseudo-scientific mumbo-jumbo wouldn't mean a thing if the physician would spend adequate time with his patient. But musculoskeletal aches and pains, whiplash injuries imagined and real, are too mundane for the internist who seeks an intellectual challenge, too time-consuming for the family practitioner with a full waiting room, and perhaps too litigious for the orthopedist. So they land in the welcoming, soothing hands of the chiropractor. And they keep coming back again and again, only too willing in the end to write their legislator singing the praises of that marvelous "science" that took away their pain. And if in the process they get even with those unsympathetic doctors who wouldn't pay attention to them, so much the better.

So if you don't want to have to write to your legislator again next year and the next year to urge him to vote against a similar bill again, why not spend that extra time with your patient; perhaps in a few years the problem will go away.—WJB

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Chiro clips

THIS IS AN EXCERPT from a letter to the editor of *Connecticut Medicine,* November 1977: "Several weeks ago I was called by one of the blood drawing team because she did not feel that it was appropriate for her to draw 52 ml of blood from a 2-year-old child for laboratory tests. I agreed and the sample was not drawn. A chiropractor had ordered the following tests to be performed on two outpatients, a young woman and her 2-year-old child:

SMA 6 (glucose, BUN, sodium, potassium, chloride, CO_2)

Lipase	Riboflavin
Amylase	Zinc
Cortisol	Niacin
Thiamine	Vitamin C
Pyridoxine	

"The cost for performing these tests, most of which we refer to reference laboratories, is $191.60. There was no specification as to fasting state, time of day or such other physiologic variables as are known to affect one or more of these tests.

"I find it difficult to comprehend how the information gathered from these tests could be used rationally to diagnose or treat any known ailment or combination of ailments. I do not find it difficult to visualize how medical costs can be pyramided by performing pointless tests." (Signed by a pathologist.)

Reported at the World Neurology Conference in Amsterdam, The Netherlands and subsequently in the journal *Stroke* were three patients in whom brainstem or cerebellar infarction or both occurred after neck manipulation. Two of the three injuries occurred after chiropractic manipulation. Of 22 cases on record, 12 were patients who developed the brainstem, cerebellar, or spinal cord infarction after therapeutic cervical manipulation.

The *AMA News* of November 28, 1977 reported that the New York State Court had ruled that chiropractic service does not constitute medical treatment. The ruling came in an auto accident case in which the plaintiff was seeking compensation for pain and suffering. The court held that the plaintiff was not entitled

to be covered for serious injury because his medical bill did not exceed $500 although his chiropractor bill totaled $1,455. In the ruling the court concluded that expenses of chiropractic treatment are not medical.

In Alaska the chiropractors lost a bid to excuse school children from mandatory immunization when the Superior Court judge ruled that only doctors of medicine and osteopathy have the right to decide when a child's health will be harmed by a vaccination. This came about after a serious outbreak of measles in Fairbanks and Anchorage and the departments of health, social services, and education launched a "no shots—no school" campaign. The president of the Alaska Chiropractic Society stated that he exempted a minor patient named in the suit because the child "enjoyed good health, and, in my professional opinion, immunizations could have long-range adverse effects on his health."

In Kentucky chiropractors were not authorized to submit specimens from the human body to clinical laboratories and use the lab reports in diagnosing their patients, a Kentucky appellate court ruled. The county medical society had questioned the activities of the lab and the chiropractors, since licensed medical laboratories were prohibited from accepting specimens and making reports to anyone except a licensed physician, podiatrist, dentist, or other person authorized by law. The trial court concluded that chiropractors could not submit specimens to clinical labs or receive reports from the lab for diagnostic purposes.

Meanwhile, back in old Wisconsin, the Senate sustained Acting Governor Schreiber's veto of mandated insurance coverage for chiropractic. The chiropractic lobby gained only 15 votes despite the expenditure of large sums to purchase full page ads in Wisconsin newspapers exhorting in heavy, black one-inch type: "Governor Schreiber, you must urge the legislature to override your veto of Senate Bill 108." State Senator Dale McKenna, who has announced for Lt Governor, pushed the chiropractic argument saying the bill "has to do with people that elect you and I (sic)."

And people in the Madison area should be pleased to learn that a fledgling chiropractor who is just opening his office has announced that there will be a spinal care lecture every Tuesday evening. —VSF

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A fond farewell

THE RATHER ABRUPT announcement from Ralph Andreano, PhD that he was returning to his faculty position at the University of Wisconsin evoked few cries of disappointment from within the health-care industry in Wisconsin. Certainly the effect of some of the decisions he made in his short tenure as administrator of the Division of Health will be felt for years to come. And his pronouncement that 77,000 unnecessary operations are done annually in our state has by now been recorded as indelibly as was the well known but erroneous quote that General Motors spends more on employee health coverage than it does on steel. (The fact that Doctor Andreano's statement was completely fallacious and irresponsible has already been forgotten—at least it was not mentioned in the radio news release that announced his resignation and credited him with discovering those 77,000 unnecessary procedures.)

But regardless of how we evaluate Doctor Andreano's performance in his rather short tour of duty, there has to be something wrong with a system that permits an employee of the state to come in and order sweeping changes in an industry when he has no intention of seeing them through to a reasonable conclusion. It is just too easy to rush in with guns blazing and shoot up the place when you know you're not going to hang around and clean up the mess.

Let's hope his successor is a bit more deliberate and hangs around long enough to answer for his mistakes.—WJB

Dr Armand Quick

THEY BURIED A GIANT on January 30. He was about five and a half feet tall. The *Milwaukee Sentinel* called him "a household word in every hospital laboratory throughout the world." But to two generations of Marquette medical students he was a lot more than that. He was the man we had to impress if we were going to make it into the second year. He was the man who caused a hundred pairs of palms to sweat as he circulated among us with that little smile lighting his gnome-like face, peeking into his grade book as he walked up and down the aisle. He was our status symbol and our super star. His was the name we mentioned when the word Marquette didn't seem to be enough.

He had a knack for livening his lectures with bits of medical history—especially when the topic had anything to do with blood. And if he happened to have been directly involved with the history-making, so much the better. That all of his ideas weren't immediately accepted by his competitors only enhanced our interest more. (He was not a shrinking violet.) The picture of our David taking on the Goliaths of biochemical research excited us all—and we rooted for him, knowing he'd win in the end. And of course he did.

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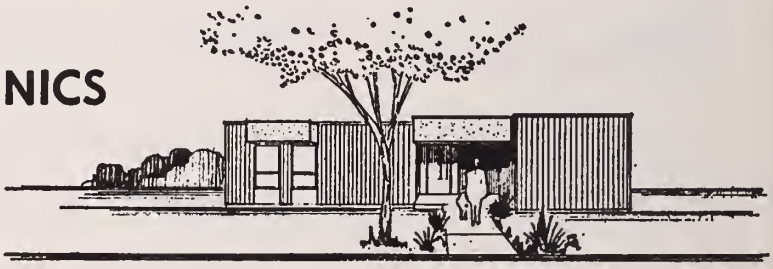

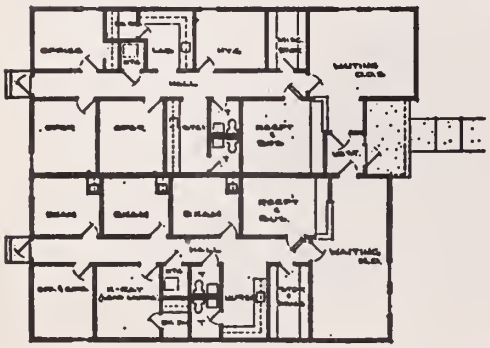

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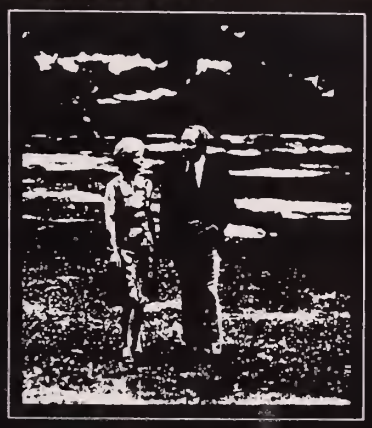

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To the Marquetters who left the Milwaukee area after graduation, those memories are enough; but for those who remained close by he was a constant, continuing source of inspiration. Reaching age 65 and then 70, he barely paused, and when he surrendered chairmanship of the Biochemistry Department, he kept right on working, concentrating more than ever on his writing, leaving a heritage of numerous scientific papers and books, so that succeeding generations will know him, too. They will know him, but they will not have had the privilege of loving him as we did.

He was Dr Armand Quick.—WJB

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State medical journal readership

THE STATE MEDICAL JOURNAL Advertising Bureau, the organization selling national advertising for a group of 34 state medical journals, including the *Wisconsin Medical Journal,* and their sales representative, The Williams and Wilkins Company, commissioned Health Industries Research to conduct a study of readership of 10 state medical journals. Ten journals were chosen to obtain a sufficient geographical cross section so that the results could be considered applicable to all state journals. The journals chosen represented large and small states throughout the United States. The survey provided measurements of reading frequency, reading patterns, type of reading, and attention paid to advertising.

The conclusion of the survey was that state medical journals were extremely well read. An average state journal was read by 79% of its audience each issue and 96% read at least one of four issues. The vast majority of readers of state journals indicated they "read articles of interest and looked through their main pages" or at least "read the Table of Contents and articles of interest only." Nine of 10 readers wanted to continue receiving the state medical journals.

Although the *Wisconsin Medical Journal* was not one of the 10 journals surveyed at this time, it was included in a sampling of nine states in 1970. This was a study of physician interest in 14 medical publications. The research analyst concluded that given a standard operating procedure of the state journal of any state would rate very high in physician interest. Conversely, physician DISinterest was extremely low.

In most of the states surveyed *Medical Economics* and the *Journal of the American Medical Association* were of more interest to the physicians than their own state medical journal. Only in Wisconsin was there more physician interest expressed in the state medical journal than in any other publication. *JAMA* and *Medical Economics* were second and third, actually almost tied. Physician DISinterest was rather modest

continued on page 18

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Surgery and the family history

Jerome J DeCosse, MD, Milwaukee, Wisconsin

From the Division of Surgery, The Medical College of Wisconsin

AT A TIME of rapid scientific advances, surgical practitioners and trainees alike seem preoccupied with diagnostic maneuvers such as liver screening panels, ultrasound, and computerized axial tomography (CAT) scanning. The power of a thorough historical inquiry and of a meticulous physical examination appears lost within an overwhelming array of laboratory technology. When charts are examined, it is uncommon to find more than cursory statements beyond a description of the patient's current illness.

In fact, a "quiet revolution" has been occurring during the past few decades in the value of the family history. Familial, presumably genetic, associations of numerous oncologic, metabolic, central nervous system, and muscular disorders now are recognized.

Aside from importance to epidemiological investigators, a carefully documented family history has immediate practical value to the patient and to his family. A few examples can be taken from oncology.

A family background of breast cancer should direct the surgeon to biopsy a breast tumor in an otherwise equivocal setting.[5] The same family background should lead to annual physical examination and mammography in family members at risk who otherwise would be regarded as too young for intensive scrutiny.

A family history of endocrine disease should direct investigation of a patient with peptic ulcer disease for suspected Zollinger-Ellison syndrome,[9] increase the aggressiveness of operation for hyperparathyroidism,[3,8] and lead to scrutiny of other family members for asymptomatic endocrine disorders. Genetic markers, such as calcitonin, can be determined in appropriate circumstances.

The autosomal dominant inheritance of familial polyposis is well recognized. Less well known is identification of colon cancer family syndromes.[6,7] Polyps may or may not be present, but colorectal cancers are very common, and members of these families merit the same intensive periodic surveillance by proctosigmoidoscopy and barium enema examination.

From numerous other examples of surgically important inherited biochemical defects, a few can be cited: $alpha_1$ anti-trypsin deficiency and pulmonary emphysema and cirrhosis[4]; hyperlipoproteinemia and cardiovascular disease[2]; and, succinylcholine-esterase deficiency and malignant hyperthermia affecting operative risk.[1]

History taking is simple, inexpensive, and productive. Patients often forget or hide important information unless they are asked. Questions should be tailored to the disease being evaluated. Familial associations do not necessarily reflect genetic inheritance; these groupings may reflect environmental exposure or random association of common diseases.

It is all too infrequent that we as surgeons have an opportunity to practice preventive medicine. A carefully elicited family history may not only reveal important clues to the patient's disorder and management but also may provide the link to identifying other patients at risk for whom appropriate prevention or early diagnosis can be generated.

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WISPAC—Our tool for political battle

YEARS AGO, the attitude of physicians toward political involvement was one of passive indifference. There was little reason for doctors to enter the political arena. Seldom did the government become involved in the private practice of medicine. Physicians could devote full time to providing quality medical care for their patients.

Then came Medicare and Medicaid, health planning and certificate-of-need, the malpractice crisis, and government cost-control regulations. Medicine was never to be the same. The government was involved.

WRIGHT

Consequently, physicians in recent years have had to take up the tools of political battle and enter the arena. We've done so because we have an unusual expertise in health care and special concerns for the health of people. We demand a voice in the development of state health policy and we want to influence government decisions in a manner that is beneficial to the public and our profession.

Our tool for political battle is WISPAC—the Wisconsin Physicians Political Action Committee. Last year more than 1,400 Wisconsin physicians were members. The purpose of WISPAC is to help people get elected to public office who are supportive of medicine's view. Whether we like it or not, our political system is structured so that candidates for public office need money to run their campaigns. They receive money and other help to run their campaigns. They receive money and other help from those people and groups with whom they find general agreement on the issues.

In the 1976 election campaigns, WISPAC contributed just over $25,000 to the campaign funds of 112 candidates for the state legislature. Ninety-two of them, or 82%, were elected. Perhaps as important as our success ratio was the process that we used to arrive at our endorsement decisions.

The process began with Physicians Alliance local committees in counties all around the state. These committees, consisting of physicians and their spouses, initiated an interview session with each legislative candidate in their area. The interviews were informal, but thorough and covered a variety of health-related issues. Each committee at the conclusion of its interviews for each race voted to recommend WISPAC support for one candidate. The recommendations in every instance were based on either a favorable legislative voting record or an indication of support for important health-care issues.

All in all, physicians and their spouses donated more than 1,400 hours to the interview process.

Each recommendation by local Physicians Alliance committees was carefully considered by the WISPAC Board. Once the WISPAC endorsement was made, the financial contribution was then delivered to the candidate.

As a result, WISPAC endorsements in 1976 were made with a thorough understanding of where each candidate stood on health issues. I don't believe that there's another organization, association, or union in the state that was as thorough and fair in making legislative endorsements as was WISPAC and the Physicians Alliance. The partnership that we established during the 1976 elections was effective and will be an ongoing one.

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Our goal, of course, is to put the physician back in the forefront of health policy formation in Wisconsin by electing people to office who respect the view of medicine. To succeed, our political involvement must be ongoing.

The ancient historian, Plutarch, was correct about the continuing importance of politics when he wrote:

They are wrong who think politics is like an ocean voyage or a military campaign, something to be done with some particular end in view, something which leaves off as soon as that end is reached. It is not a public chore to be gotten over with. It is a way of life.

WILLIAM E WRIGHT, MD
Chairman, WISPAC
Mondovi ■

WISPAC—Wisconsin Political Action Committee

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"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

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Identification of hormone-dependent breast cancer patients

HORMONES, THE chemical messengers which play an important role in regulating the human body, have long been known to affect some breast cancers. Additive treatment with estrogens or androgens or ablative treatment (oophorectomy, adrenalectomy, hypophysectomy, or antihormones like tamoxiphen) have a favorable effect on about one-third of all patients with metastatic breast cancer, but tumors in the other patients continue to grow in an autonomous manner.

Receptors for the female hormone estrogen are located in the mammary tissue (in very low levels), endometrium, vagina, and hypothalamus. Estrogen receptors also are found pathologically in breast cancer, uterine cancer, 30% of malignant melanomas, and some cancers of the kidney; but so far they have been only useful clinically in breast cancer. These receptors are cytoplasmic proteins which bind estrogen strongly and specifically. The interaction of the estrogen steroid with the receptor protein is believed to be the initial event in a series of responses characteristic of estrogen stimulation.

In 1974 an international workshop held by NCI[1] showed that 55-60% of breast cancer patients who are estrogen receptor positive (ER+) respond to endocrine treatment. Patients with estrogen receptor negative (ER−) tumors have a response rate less than 10%. The responsive tumors seem to be sensitive, not for a specific hormone treatment, but to a change in the endocrine environment. Estrogen receptors are needed for the tumor to be sensitive to these changes.

In trying to determine which patients will respond to endocrine treatment, some Belgian doctors[2] recently reported that receptor concentration was more important than bone involvement or age. They believed that all patients may be hormone dependent, but to variable degrees.

The absence of estrogen receptor in primary breast tumors is associated with early recurrence, independent of other known prognostic factors such as axillary lymph node status and tumor size[3]. ER− patients constitute a very high-risk group, with higher and earlier recurrence regardless of primary size, location of the tumor, number of involved axillary nodes, age, or adjuvant therapy. As a group ER− patients were younger (under 50) than ER+ patients. Patients who are ER− with positive nodes have a recurrence rate of 50% at 18 months, so they should be treated aggressively with combination chemotherapy.

But how can the ER+ patients who do not respond to endocrine manipulation be identified? Horwitz, et al[4] have suggested that progesterone receptors are also required for endocrine treatment to be effective. Approximately 56% of breast cancers contain both estrogen and progesterone receptors. Progesterone receptors are not present in ER− tumors. About 85% of tumors which have both receptors respond to endocrine treatment. Estrogen receptors are necessary for the synthesis of progesterone receptors. Estrogen combines with the receptor in the cytoplasm, then moves to the nucleus where its action is expressed. If this occurs, the pathway for the synthesis of progesterone receptors is possible. The presence of both receptors indicates that the necessary endocrine machinery is present and the tumor under partial endocrine control, which apparently increases the likelihood of a favorable response to treatment. Remissions occurred only in patients with progesterone receptors.

Lactalbumin, which directs the synthesis of lactones for milk, is present in lactating breasts and some breast cancers; its presence corresponds to some of the ER+ but not ER− patients and indicates the integrity of transcription in the nucleus.

Endocrine receptor measurements help guide therapy by helping select between endocrine and cytotoxic treatment at the time of the first treatment rather than waiting for recurrence. Some patients may benefit from endocrine therapy even though the response is not clinically discernible; however, it is known that endocrine treatments have never achieved cure of advanced breast cancer patients. Possibly a combination of endocrine and chemotherapy will prove to be the best therapy, but this must still be tested in controlled clinical trials.

In order to help learn about the estrogen receptor status of breast cancer patients, Dr David P Rose, who directs the estrogen receptor assay service at the Wisconsin Clinical Cancer Center, encourages all Wisconsin physicians to have endocrine receptor status of the primary breast carcinoma studied at the time of mastectomy and any recurrences evaluated. Especially if a patient of yours who was tested for estrogen receptors at the time of the first primary has a recurrence, he would like to see the new growth.

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—DOROTHY J BUCHANAN-DAVIDSON, PHD

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Supported by NCI Grant No. 5 R18-CA-16405-03.

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Beloit Memorial Hospital, April 6.

Sheboygan Memorial Hospital, April 20.

See YELLOW PAGES for the program.

for these same three publications and at least twice as great for all the other 11 publications listed in the survey.—VSF ■

Old hat

WHEN THE ARTICLE entitled "Renal Complications During Sulfonamide Therapy," which appears on page S/15 in this issue, was routed through the Editorial Board, one of the Board members commented: "Old hat—to those who lived through the sulfa era." And it did recall the first news from Germany in the 1930s of prontosil, the bright red forerunner of the sulfonamides. Sulfanilamide was followed by sulfapyridine and sulfadiazine—a decade before penicillin. The initial doses were massive—18 sulfa and 18 soda bicarb tablets in a single dose. The complications, especially renal, were in proportion.

I remember as an intern getting flasks of a home brew called sodium sulfapyridine from Doctor Wesley Spink at the University of Minnesota. This was given intravenously to critically ill children with "whooping cough pneumonia." Also, it recalls the administration of intravenous methylene blue to treat the cyanosis resulting from the sulfa—supposedly converting the sulfhemoglobin to methemoglobin.

Early in World War II every GI carried in his first-aid kit a packet of sulfa crystals to be poured into wounds. The sulfa caked horribly in abdominal wounds, and resulted in the usual renal complications when absorbed. This practice was soon discontinued. Also, in World War II, there occurred an early example of a resistant strain when the Australian variety of Neisseria did not succumb to sulfa.

Conclusions: (1) to reminisce is a privilege; (2) experience is hard to come by.—VSF

For sale

RECENTLY A Wisconsin chiropractor wrote and requested that a "for sale notice be placed in your magazine" *(Wisconsin Medical Journal)*. This followed:—"FOR SALE: Like-new endocardiograph. Determines heart muscle tone, as well as other heart conditions."

By definition endocardiography is defined as an electrocardiograph with an exploring electrode within the chambers of the heart.

It is alarming that an endocardiograph could have gotten into the hands of a chiropractor. What caliber of medical supplier would provide it? There certainly is nothing in the concept or legal practice of chiropractic that permits the use of this sophisticated bit of equipment.

P.S. The ad was not accepted!—VSF ■

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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SPECIAL

Characteristics of Wisconsin's physician population: results of a 1976 survey

Jane Cloak, Research Analyst, Bureau of Health Statistics, Division of Health, Wisconsin Department of Health and Social Services
Madison, Wisconsin

• For the fifth consecutive year, physicians licensed in Wisconsin received a survey form with their license renewal notices sent in November 1977 by the State Department of Regulation and Licensing. The survey is part of a system sponsored by the National Center for Health Statistics (NCHS). Since 1974, under the Cooperative Health Statistics System (CHSS), the Center has collected health resource statistics through state licensing systems, in a manner similar to that used for birth and death information. Twenty-six states are currently under contract to collect health manpower data for CHSS. The Center plans to have all 50 states in the system by 1980. The information collected is used by state and local health planning agencies in carrying out activities mandated by the National Health Planning and Resources Development Act of 1974 (PL 93-641) and the Health Professions Educational Assistance Act of 1976 (PL 94-484). Data is used to define areas of shortage and to study trends in the distribution of health resources. This information informs various policy and planning decisions by state and federal agencies and is used by local groups in justifying applications for funds and in defining priorities for action. Pertinent information from the 1976 survey follows.

In November 1975 a survey was mailed to every physician then licensed to practice in Wisconsin. The survey was an attachment to the license renewal notice sent to physicians by the Medical Examining Board, State Department of Regulation and Licensing. The purpose of the survey was to collect statistical information for the use of local, state, and federal agencies concerned with planning, regulation, and education in the health field.

Content of the survey was based upon a minimum data set developed by the National Center for Health Statistics as part of a state-federal cooperative health statistics system. Survey information included demographic items (birthdate, sex, descent, marital status, and location) and education items (year and place of graduation from medical or osteopathic training, boards for which certified, and status as a resident or fellow). The survey also asked whether the licensee was active as a physician; and if active, whether full time, part time, or in a volunteer capacity only. Physicians not active were asked to specify temporarily inactive, unemployed, active in another occupation, or retired. For active physicians, a series of questions followed concerning location of practice, principal setting of practice, employer and hours spent per week in patient care (principal and secondary setting), teaching, research, and administration.

SURVEY RESPONSE

Excluding physicians known to be retired or inactive, response to the survey was 90.5% of all physicians located in Wisconsin. Five hundred and forty-five (545) physicians with Wisconsin mailing addresses did not respond. Information on location, age, and year and place of graduation of nonrespondents was obtained from the Medical Examining Board. These physicians are considered active in all analyses of the data.

The total number of physicians licensed in Wisconsin and located in the state in April 1976 was 5,992. Of these, 5,759 were considered to be active, including 545 nonrespondents, 280 active part-time or volunteer only, and 4,934 full time. Two hundred and thirty-three (233) licensed physicians were inactive.

Nonrespondents as a group were slightly younger than respondents: 34% were under 40, while 31% of all physicians are under 40. Physicians in general practice and family practice were more likely to respond to the survey than other physicians; only 6.4% of general practitioners and 5.8% of family practitioners did not respond. Physicians in rural counties* were less likely to respond (13.2% nonresponse) than were physicians in urban counties (8.3% nonresponse). Foreign medical graduates were slightly more likely to respond (8.6% nonresponse) than physicians generally.

SURVEY FINDINGS

Specialty

Fourty-four percent (44%) of Wisconsin physicians are in one of the primary care specialties. Of these, the largest number are in general practice (1019), followed by internal medicine (732), pediatrics (312), obstetrics-gynecology (307), and family practice (172). There are 462 general surgeons in the state. Of the other specialties, the most numerous are psychiatry (324), nuclear medicine (250), anesthesiology (232), and ophthalmology (205).

(The specialty designations used in the survey are those listed by the Medical Examining Board in its annual directory of licensees. Physicians' specialties as listed with the board are printed on the renewal notice and licensees are asked to verify or change the designation as necessary. A specialty is listed by all but 270 physicians in Wisconsin. The specialty designation is self-specified and does not imply specialty board certification or other credentialling.)

Geographical distribution

By latest estimate, 60% of Wisconsin's population lives in one of

*Rural counties are defined as those outside Standard Metropolitan Statistical Areas. By this definition, 16 Wisconsin counties are considered urban counties and 56 counties are rural counties.

the 16 urban counties in the state.* Seventy-six percent (76%) of the state's physicians are located in these metropolitan areas. In the state's two largest counties, Dane (Madison) and Milwaukee, 29% of the state's population is served by 51% of the state's physicians, including 45% of those in primary care. The presence of a medical school in each city is responsible for part of this concentration. Recently, staff and committees of the state Health Planning and Development agency have attempted to determine which areas of the state are experiencing a shortage of medical care. No one formula, it was found, adequately reflects the complex interactions of physician location, physician activities other than patient care (such as teaching and research), organization of medical care, and barriers to patient access such as travel time and cost. By the simplest measure, physician ratio-to-population, 45 of Wisconsin's 72 counties are below the rule-of-thumb indicator of one physician for each 1500 population. Eight counties: Dane, Wood, Milwaukee, Oneida, Eau Claire, Ashland, Winnebago, and Brown, in that order, are the best supplied with physicians, having from 1:306 to 1:952 physician-to-population ratios. At the other end of the scale, three counties, Greene, Lafayette, and Price, have fewer than one physician to each 4000 population, and another four counties, Adams, Florence, Buffalo, and Iron, have ratios between 1:4000 and 1:3000.

Despite the more favorable overall physician-to-population ratio in urban areas, there may be a greater number of *persons* affected by a shortage of medical care in urban areas than in rural areas. One measure, used by the federal government in allocating funds for health maintenance organizations, identifies certain census tracts in Green Bay, Superior, Kenosha, Racine, and Milwaukee as "medically underserved."

*US Department of Commerce, Bureau of the Census. *Current Population Reports Series P-26.* Estimates of the Population of Wisconsin Counties and Metropolitan Areas: July 1, 1975 Revised and 1976 (Provisional) July, 1977.

The same formula also identifies 12 counties: Adams, Bayfield, Burnett, Florence, Forest, Iron, Lafayette, Marquette, Menominee, Price, Sawyer, and Taylor as underserved, together with certain townships in 30 additional counties. The formula, based on a countywide physician-to-population ratio, takes into account the number of persons over 65, the infant mortality rate and the percent of the population living in poverty.

Practice characteristics

Of physicians active in Wisconsin and responding to the survey, 29% were in solo practice, 10% were in partnership, and 32% were in group practice. Eighteen percent (18%), including residents, work for local, county, state, and federal government. Five percent (5%) are self-employed in a contractual arrangement and 4% are nongovernment employees, with the remainder indicating "other" employment.

Despite the popular image of the solo practitioner as a rural or small town phenomenon, 74% of solo practitioners are in urban areas. The view of solo practice as an old-fashioned mode of practice is nearer to fact: while 55% of physicians aged 65 and over are solo practitioners, only 14% of physicians aged 35 to 39 are in solo practice.

Physicians were asked to state the number of hours spent each week in patient care. For all physicians, the average reported was 49 hours a week in primary and secondary patient care settings. Surgeons reported more hours per week than physicians in other specialties; general surgeons reported an average of 57 hours per week in patient care.

Thirty percent (30%) of physicians reported hours in more than one patient care setting. Physicians who reported hours in a secondary setting averaged 16 hours a week in the secondary setting. Because the response to this question indicated that information on secondary practice locations might be of importance in understanding the distribution of medical services in both urban and rural Wisconsin, the 1977 survey was expanded to collect this information.

Age

The age at which physicians retire will be one factor determining the need for continued expansion of medical training facilities. Data from the 1976 physician survey was compared with earlier data available from the American Medical Association to reach a rough approximation of the percentage of physicians in each five-year age group over 55 who retire. Two assumptions were made in comparing 1971 AMA data with 1976 CHSS survey data. One assumption was that very few physicians over the age of 55 move to Wisconsin and enter practice. The other assumption was that AMA data is essentially comparable to CHSS data; *ie,* that the two surveys cover the same population of physicians.

Allowing these assumptions, comparison of the two surveys showed that of physicians who were between 55 and 59 years old in 1971, 89% were still in practice five years later. In the next five-year cohort, those aged between 60 and 64 in 1971, 82% were still in practice in 1976, when they were between 65 and 69 years old. Fifty-nine percent (59%) of the group aged 70-74 in 1976 was still in practice; 50% of the group 75 to 79 in 1976 was still in practice, and more than one-third of those who were over 75 in 1971, and in their 80s in 1976, were still in active practice. Whether future cohorts of physicians will choose to remain in practice into their 70s or 80s is, of course, unknown.

The age distribution of physicians by specialty and by geographical distribution is of interest in attempting to predict future needs and to assess the effect of present policies and programs. In 1976 Wisconsin physicians in rural counties were slightly older (average age 49) than urban physicians (average age 46). Physicians in primary care specialties were older (average age 48) than physicians in other specialties (average age 46). General practitioners were, on the average, 54 years old.

These averages, however, mask changes which appear to be occurring when these characteristics are compared from age group to age group. For instance, it is not sur-

prising to find that 94% of physicians under 30 are in urban areas, given that residency programs are located almost exclusively in Madison and Milwaukee. Of physicians between 30 and 34, 80% are located in urban counties.

However, an intriguing fact is that 26% of physicians between 35 and 39 are located in rural counties. This is a larger percentage in rural areas than is the case for physicians in their 40s, and represents a reversal of a uniform pattern for all older age groups, in which a decreasing proportion is located in rural counties in each successively younger five-year age group. (Among physicians 65 and over 31% are in rural counties; 60 to 64 and 55 to 59: 29% rural; 50-54: 28% rural; 45-49: 24% rural and 40-44: 21% rural.)

A similar reversal of trend is seen in choice of specialty: physicians in primary care specialties are a decreasing percentage of all physicians, from a high of 66% of physicians over 65 years old in primary care, to a low of 38% of physicians aged 35 to 39 in primary care. Then the trend reverses: 49% of physicians aged 30 to 34, and 60% of those 25 to 29 are in primary care specialties. Thus when physicians in various age groups are compared, it appears that in choice of specialty and choice of practice location, physicians now in their 30s resemble physicians in their 60s more closely than they resemble physicians now in their 40s. Since physicians under 40 represent nearly one-third of all physicians licensed and active in Wisconsin, these trends as they develop in the next few years will have a large impact on the availability of care throughout the state.

The Bureau of Health Statistics plans to continue its survey of physicians and other licensed health occupations. With changes in licensing procedures, the collection of information is now biennial. Physicians were surveyed in November 1977 with the license renewal for 1978-79. The next survey will occur in late 1979. ■

NEWS YOU CAN USE

HEW PUBLICATIONS AVAILABLE TO PHYSICIANS

The Department of Health, Education, and Welfare's Cancer Institute is offering several publications on cancer and cancer treatment to physicians. The Institute is offering professional/technical publications as well as layman/patient publications at no charge. The layman/patient publications could be placed in physicians' waiting rooms. Interested physicians can obtain a listing of the publications by writing the Office of Cancer Communications, National Cancer Institute, Bethesda, Maryland 20014.

AMERICANS AND HEALTH INSURANCE

Nearly 144 million Americans under age 65 have some form of catastrophic health insurance, according to the Health Insurance Association of America. That figure does not include the 23 million persons covered by Medicaid and another 24 million covered by Medicare. It is estimated that less than one half of one percent of patients had illness expenses larger than $4,600 in 1976.

MEDICAL CARE PRICES INCREASE AT SLOWER RATE

For the third consecutive month, the rate of increase in medical care prices has declined. Last month, the rate of increase in the medical care component of the consumer price index was 0.6% compared to 0.7% in May and a 0.8% increase in April. The rate of increase in hospital charges also declined in June to 0.7%, compared to 0.9% in May and April. Physician fees increased at a rate of 0.7% which was the same as the increases in the all-items index and the all-services index.

NURSING SALARIES RISE

In the last three years nursing salaries have increased over 25 percent, according to a survey in *Nursing 77,* the largest nursing journal. However, nurses didn't feel that this increase was enough and pointed out that nursing wages rose at a slower rate than those of coal miners for the same period. The average salary for an experienced staff nurse around the country ranged from $3.99 an hour in the Mountain states to $7.41 in New York City. ■

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SMS negotiations seminar set for March 17-19

The SMS Physicians Alliance Division is sponsoring a negotiations seminar for physicians on March 17-19 at the Pioneer Inn in Oshkosh. The program, "The Physician Negotiator" consists of lectures on basic negotiation skills and mock negotiation sessions to test those skills. Registration fees are $20 for SMS members and $40 for nonmembers. *Registration is limited to 40 physicians.* Physicians planning to attend the program should make their motel reservations directly with the Pioneer Inn in Oshkosh. A special rate has been established for those individuals attending the seminar. To register contact the Physicians Alliance office in Madison. Members can now call toll-free to SMS headquarters: 1-800-362-9080. ■

SMS asks MEB to amend rule on amphetamines

The State Medical Society has asked the State Medical Examining Board (MEB) to amend its November 1, 1977 ban on the sale and prescription of amphetamines and amphetamine-like substances to include only Schedule II central nervous system stimulants.

Testifying at the January 18 public hearing on behalf of the Society was Darold Treffert, MD, Winnebago, and chairman of the SMS Committee on Alcoholism and Other Drug Abuse.

Doctor Treffert urged the MEB to: (1) limit the ban to central nervous stimulants listed in Schedule II; (2) notify all Wisconsin physicians and pharmacists of the specific drugs included in such a ban by both generic and trade name; (3) conduct a study in cooperation with the Controlled Substances Board on the efficacy and usage patterns of anorectics in Schedule III and IV to determine whether a ban on Schedule II central nervous system stimulants might result in abusive use of Schedule III and IV drugs as substitutes; and (4) take prompt action against physicians and others who abuse medically acceptable prescribing and dispensing patterns.

The Medical Examining Board is holding the hearing open until February 17 to allow all interested parties to submit documentation and information to the Board before its final ruling. ■

Donald Percy to speak at SMS Annual Meeting

Donald Percy, secretary of the Wisconsin Department of Health and Social Services, will be the featured speaker at the Annual Meeting's Socio-economic Luncheon on Friday, April 14 at 12:15 pm at the MECCA Convention Hall in Milwaukee.

Mr Percy is a recognized authority in the areas of health planning, finance, government relations, and academic affairs.

In addition, the Wisconsin Singers will perform on Friday, April 14 at 7:30 pm at the Presidents' Dinner at the Marc Plaza Hotel. This group of singers and dancers are selected each year from nearly 200 on-campus auditions.

Physicians also are reminded to note the following dates of the Annual Meeting Program to be held at the MECCA and Marc Plaza Hotel in Milwaukee on April 13-15:

April 12, 1:30 pm—Council Meeting

April 13-14-15—House of Delegates Sessions

April 14-15—Scientific Program

A summary of the resolutions to the House of Delegates will be published in the March issue of WMJ along with the Scientific Program. ■

Nominations open for AMA alternate delegate

Leo R Grinney, MD, Racine, recently submitted his resignation as an Alternate Delegate to the American Medical Association. Consequently, the Nominating Committee will be receptive to early nominations for this vacancy as it must be prepared to include one or more names in the slate to be presented to the House of Delegates in April. The term of office is calendar years 1978 and 1979. Please send nominations and curriculum vitae to the committee chairman, John D Riesch, MD, W180 N7950 Town Hall Road, Menomonee Falls 53051, 414/255-2500. ■

Cost-containment efforts continue

The State Medical Society's Committee on Evaluation of Delivery and Costs of Medical Care continues to meet to develop a strong, positive approach to medical containment efforts in Wisconsin. Congress has challenged health officials throughout the country to reduce the cost of health services to consumers or face imposed restrictions.

The SMS and the Wisconsin Hospital Association (WHA) are considering a public education program concerning the various successful cost-containment programs and practices in Wisconsin by physicians and hospitals, and perhaps may recommend some new ones.

These activities are in line with a joint American Medical Association-American Hospital Association statement calling for a concerted voluntary effort in the next year to hold down hospital and other cost increases. ■

Two jails receive nod; accreditation

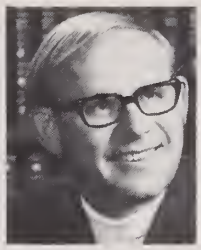
The State Medical Society's Jail Health Care Committee has recommended the Adams and Dane County Jails for full accreditation from the American Medical Association's Jail Health Care Project.

The AMA's National Jail Health Care Project Advisory Committee is now reviewing the recommendations, applications and jail survey materials and will make its accreditation decisions later this month.

Members of SMS and the SMS Jail Health Care Committee were active in the jail survey process preceding the recommendations for accreditation. The SMS Committee is presently recruiting three more jails for the accreditation process before the end of the current contract year (February 24, 1978). ■

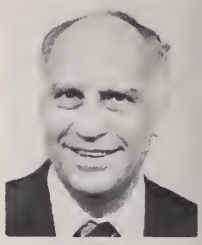
Here is a complete list of those candidates chosen for top State Medical Society offices by the Committee on Nominations. This is the slate on which the House of Delegates will vote at the Society's Annual Meeting April 13-15 at Milwaukee's Exposition and Convention Center and Arena (MECCA) and Marc Plaza Hotel. Be sure to let your county medical society delegate know your preferences in the next few weeks.

Dr Jules D Levin
In-coming President
1978-1979



Doctor Treffert

Doctor Taebel



Doctor Dettmann

Annual Meeting: Nominees awaiting the vote

☐ Darold A Treffert, MD

President-elect

Graduated from University of Wisconsin Medical School in 1958. Interned at Sacred Heart General Hospital, Eugene, Oregon from 1958 - 1959. Residency in psychiatry at University Hospitals, Madison, from 1959 - 1962. Born in Fond du Lac, Wisconsin, in 1933. Has been director of Winnebago Mental Health Institute from 1964 until present. Associate clinical professor of psychiatry at University of Wisconsin, Madison, since 1965 to present; chairman, SMS Committee on Alcoholism and Other Drug Abuse, 1967 to present; chairman, SMS Section on Psychiatry, 1974 - 1976; delegate, SMS Section on Psychiatry, 1973 to present; president, Wisconsin Psychiatric Association, 1974 - 1975 and first president to be reelected, 1975 - 1976. Chairman, Controlled Substances Board of Wisconsin, 1969 to present; member, Critical Health Problems Committee, Wisconsin Department of Public Instruction, 1973 to present, representing the State Medical Society of Wisconsin; legislative representative, American Psychiatric Association; Wisconsin District Branch representative. Fellow of American Psychiatric Association and American College of Psychiatrists; member of the Council of Wisconsin Psychiatric Association; member of the council of American Association of Psychiatric Administrators; and member of Alpha Omega Alpha. Appointed by American Psychiatric Association as program committee member of the Hospital and Community Psychiatry Institute, a national meeting of psychiatrists and allied professionals in mental health. On Editorial Board of *Journal of Autism and Childhood Schizophrenia.* Honored as Mental Health Man of the Year in 1971 by Wisconsin Mental Health Association. Author of 35 publications and major papers presented at the last five American Psychiatric Association Annual Meetings. Several of these publications have been in the AMA's *Prism* Magazine and the AMA News *Impact* section. Author of article on "Psychopolitics of Health Planning" which was published in the *Wisconsin Medical Journal* (January 1973) and received wide distribution within the state and nationally. Faculty member at numerous institutes and symposia in Wisconsin and nationally. Participant and presentor in SMS Work Week of Health in 1973 and 1975. Served as host at Winnebago for SMS Work Week of Health in 1977. Especially interested in the problems of health-care planning.

Members, Committee on Nominations

John D Riesch MD, Menomonee Falls (Chairman)
Chesley P Erwin MD, Milwaukee (Secretary)

David N Goldstein MD, Kenosha
Leo R Grinney MD, Racine
District One

James N Moore MD, Madison
James J Tydrich MD, Richland Center
District Two

Vernon M Griffin MD, Mauston
District Three

James D Kramer MD, Wausau
District Four

Kenneth M Viste Jr MD, Oshkosh
District Five

Wesley E McNeal MD, Green Bay
District Six

John A May MD, Baldwin
District Seven

Joseph M Jauquet MD, Ashland
District Eight

Joel E Taxman MD, Milwaukee
Specialty Sections

☐ Duane W Taebel, MD

Vice-speaker of the House of Delegates

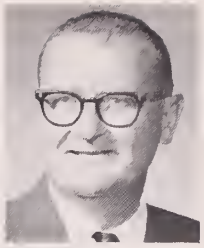
Graduate of University of Chicago School of Medicine, 1960. Internship at University of Chicago Hospital, 1960 - 61. Internal medicine residency at University of Chicago Hospital, 1961 - 64 and was chief resident in medicine, 1963 - 64. Fellow in gastroenterology, 1964 - 66, and was instructor, Dept of Medicine, University of Chicago Hospital. Served in US Army Hospital, Fort Devens, Mass, 1966 - 68. Received Wisconsin license in 1966 when joined Gundersen Clinic-LaCrosse Lutheran Hospital. Board certified in internal medicine, 1968, and recertified in 1974. Board certified in gastroenterology, 1972. Was member of American Society of Cytology and Alpha Omega Alpha Honor Medical Fraternity. Holds memberships in American Gastroenterology Association and American Society of Gastrointestinal Endosopy. Is Fellow, American College of Physicians. Is 1978 chairman of the Department of Medicine, Gundersen Clinic, Ltd, and has served as chief-of-staff, LaCrosse Lutheran Hospital. Was president of LaCrosse County Medical Society, 1976. Has been delegate to State Medical Society since 1972 and vice-speaker of the House of Delegates in 1978. Was member of SMS ad hoc committee on redistricting. Serves on Board of Control of Wisconsin Professional Standards Review Organization (WisPRO), 1975 to present. Also is on the WisPRO West Central District Review Council. Active in alcohol-related programs: director, LaCrosse Lutheran Hospital Detoxification Center; various consulting positions regarding alcohol abuse problems including appearance on state educational TV program on drug abuse.

Doctor Scott

Doctor Williams

Doctor Stuff

Doctor Natoli



Doctor Riesch

☐ John E Dettmann, MD

Delegate to American Medical Association (1978-1979)

Graduate of University of Louisville, Kentucky, Medical School, 1946. Interned from April 1946 - September 1947 at Milwaukee County General Hospital. Licensed in Wisconsin in 1947. Served in United States Air Force from October 1947 - September 1949. Conducted a general practice in Brillion, Wisconsin, from 1949 - 1951. Has practiced in Green Bay since 1952 and is a member of the Deckner Medical Group and is on the medical staffs of Bellin Memorial, St Vincent's and St Mary's hospitals in Green Bay. In 1963 was president of the Brown County Medical Society and also has been president of the Northeastern Wisconsin Health Planning Council and cochairman of the Brown County Health Planning Council. Is a member of the Green Bay Community Council and the Brown County Cancer Society and a state director of the American Cancer Society. Served as an alternate delegate to State Medical Society in 1960 - 1962 and as a delegate from 1965 - 1966. From 1963 - 1966 served on the SMS Committee on Cancer. Was a councilor of the State Medical Society from the Sixth District, 1966 - 1974. Served as president of the SMS from 1974 - 1975, also served on the Executive Committee of the Council, was chairman of the Council's Finance Committee, served as vice-chairman of the Council in 1971. Was an active spokesman for the Society in hearings conducted by the Governor's Health Planning and Policy Task Force. A native of Rock Springs, Wisconsin, he did his undergraduate work at the University of Wisconsin, Madison. Presently serving on board of directors of Wisconsin Health Care Review, Inc (WHCRI), 1976 - 1979.

☐ John Kimball Scott, MD

Delegate to American Medical Association (1979-80)

Graduate of Ohio State University College of Medicine, 1954. Interned at White Cross Hospital, Columbus, O, in 1954 - 1955 and residency at University Hospital, Columbus, O, 1955 - 1958. Received license to practice medicine in Wisconsin in 1958. Has been in practice of otolaryngology in Madison since 1958. Was certified by American Board of Otolaryngology in 1959. Is associate clinical professor of otolaryngology at University of Wisconsin. Is on active staffs of St Mary's, Madison General, and University Hospitals, all in Madison. Is preceptor for fourth year residency program at Madison General Hospital. Past president of Dane County Medical Society 1975. Has been a delegate from Dane County Medical Society to the State Medical Society of Wisconsin for last seven years. Presently alternate delegate to AMA, 1976 - 1977. Served on State Medical Society reference committees, 1971 through 1973 and was a reference committee chairman in 1972 and 1973. Has been member of State Medical Society's Committee on Cancer since 1967 and its chairman since 1971. Member of SMS Committee on Medicine and Religion. Is secretary-treasurer of WISPAC. Has been national delegate to American Cancer Society since 1969 and is past president of its Wisconsin Division. Past president of State Society of Otolaryngology. Is president-elect, Wisconsin Chapter of American College of Surgeons. Member of American Academy of Ophthalmology and Otolaryngology since 1960 and American College of Surgeons since 1962. Is chairman of state commission on cancer, American College of Surgeons, working with Ancillary Committee of American Cancer Society and Wisconsin Clinical Cancer Center. Member of Society of Head and Neck Surgeons since 1963. Member of American Laryngological, Rhinological and Otological Society since 1972. Chairman of Board, WisPRO.

☐ DeLore Williams, MD

Delegate to American Medical Association (1979-80)

Graduate of the former Marquette University School of Medicine. Received internship at Milwaukee's Columbia Hospital, 1948 - 49. Did residency at VA Hospital, Milwaukee, 1949 - 51 and 1953 - 54. Received license to practice medicine in Wisconsin, 1949. Before completing residency, served in the US Air Force. In 1957 was certified by American Board of Internal Medicine. Practices in West Allis and is clinical instructor at Medical College of Wisconsin. Was chairman of SMS Ad Hoc Committee on Quackery. Served as 12th District and 1st District SMS Councilor, 1971 - 77. Served on former Commission on Public Policy as regular member between 1971 and 1972 and as ex officio member between 1973 and 1978. Was member of Council's Finance Committee from 1971 to 1977. Is also member of Wisconsin Society of Internal Medicine, American College of Physicians, and American Society of Internal Medicine. Since 1972 has been delegate to State Medical Society. Elected AMA delegate in 1976 for the 1977-78 term. For past seven years has served on his county medical society's Legislative Policy Committee, four of those years as chairman. Also has been active on county's Editorial Board and Medical School Liaison Committee. Has served the past four years on the County Medical Society Long-range Planning Committee. For past seven years has served as member of West Allis Memorial Hospital's Board of Directors. Is member of West Allis Memorial Hospital Finance Committee Public Relations Committee, Quality Care Committee, and Long Range Planning Committee, and is chairman of its Development Council. Served as member of West Allis Chamber of Commerce Board of Directors from 1962 to 1974 and was president of Chamber of Commerce in 1963. Member of Board of Directors of Central Bank, West Allis, 1973 to present.

☐ Patricia J Stuff, MD

Alternate Delegate to American Medical Association (1979-80)

Graduate of Woman's Medical College. Received internship at St Luke's Hospital, Chicago, Ill, 1955 to 1956. Served residency at Sacred Heart Hospital, Yankton, SD, 1956 to 1957. Received license to practice medicine in Wisconsin in 1957. Began general practice of medicine in

Bonduel same year. Has been delegate to State Medical Society of Wisconsin from Shawano County Medical Society, 1966 - 1973 and alternate delegate in 1977 - 1978. Became vice-speaker of House of Delegates in 1973. Also has served as member of State Medical Society's Nominating Committee and of House of Delegates reference committees. Member of board of directors of Wolf River Mental Health Clinic, founded by citizens' committee she organized in 1964. Headed clinic's board of directors in 1966. Served as vice-chairman of Unified Mental Health Board of Shawano and Waupaca counties and chairman of its planning committee 1974 - 1975. Is chairman of credentials committee of Shawano Community Hospital. Was recipient of "Woman of the Year" award by Shawano County Business and Professional Women's Association in 1971 and is listed in *Who's Who of American Women*. Serves as Adjunct Professor, University of Wisconsin-Oshkosh, 1975 to present.

☐ **Cornelius A Natoli, MD**
Alternate Delegate to Amercan Medical Association (1979-80)

Born in Utica, New York, 1930, he received BS degree in 1952 from Niagara University, and graduated in 1956 from Georgetown University School of Medicine. Internship and residency in surgery at Barnes Hospital, St Louis, Missouri, followed by three years of urology residency at Barnes Hospital. Private practice in Salt Lake City, Utah, from 1961 - 1969; held offices in Utah State Medical Association, Public Health Committee, and Utah Urological Society. Member of Gundersen Clinic, Ltd, from 1969 to present. Clinical assistant professor of surgery (urology), University of Wisconsin Medical School. Is president-elect of LaCrosse County Medical Society; member of American Urological Association, Wisconsin Urological Society, and American College of Surgeons. Past chairman LaCrosse County Insurance Advisory Committee; past member of SMS House of Delegates and served on its reference committee on finance and chaired reference committee on reports of officers; member of past SMS Commission on Medical Care Plans and currently is a member of WPS Board of Directors; past member of SMS House of Delegates Nominating Committee; and presently serves as Third District councilor of SMS. Is a member of WisPAC. Also member of Board of Directors, Gundersen Clinic, Ltd. Member of Health Occupation Division Advisory Committee of Western Wisconsin Technical Institute.

☐ **John D Riesch, MD**
Alternate Delegate to American Medical Association (1979-80)

Graduate of University of Wisconsin Medical School in 1958. Internship and residency at Milwaukee County General Hospital, 1958 - 1963. Is assistant clinical professor of surgery, Medical College of Wisconsin. Hospital affiliations as a general surgeon: Community Memorial, Menomonee Falls (chief-of-staff, 1969 - 1970; chief of surgery, 1971 - 1972); Elmbrook Memorial, Brookfield; St Joseph's, Hartford (consulting staff); Waukesha Memorial, Waukesha (associate staff); and West Allis Memorial, West Allis. Received Distinguished Alumni Award of Whitewater University, 1972; and became a member of its Hall of Fame, 1973. Served as president of Waukesha County Medical Society in 1973 - 1974; member of Milwaukee Academy of Surgeons; Wisconsin Surgical Society; Milwaukee Medical Society (associate member); American College of Surgeons, president of Waukesha Cancer Society, 1969 - 1970, and member of Wisconsin Board of Medical Examiners in 1969. Certified by American Board of Surgery in 1965; received fellowship in American College of Surgeons, 1966. Appointed board examiner for American College of Surgeons, on medical panel of Menomonee Falls Police and Fire Commission, and on disaster committee of Community Memorial Hospital. ■

JUNE 1977 BLUE BOOK UPDATE

In the Officers of Specialty Sections of the State Medical Society listing, pages 84-85, the following changes have been made:

Allergy and Clinical Immunology
Chairman: Raymond L Hansen, MD
1000 N Oak Ave, Marshfield 54449
Delegate: S Roger Hirsch, MD
PO Box 17821, Milwaukee 53217
Alternate: Raymond L Hansen, MD
1000 N Oak Ave, Marshfield 54449

Anesthesiology
Chairman: Richard A Manhart, MD
Rte #2, Maurer Rd, Cross Plains 53528

Family Physicians
Chairman: Richard K Chambers, MD
123 Lawn St, Hartland 53029
Secretary-Treasurer: John Grade, MD
1050 Legion Dr, Elm Grove 53122

Otolaryngology
Chairman: Richard H Ward, MD
626 E Longview, Appleton 54911. ■

GAC opposes amended laetrile bill

At its January 11 meeting, the SMS Commission on Governmental Affairs voted to oppose amended Assembly Bill 240 which would prohibit anyone from obtaining laetrile except by a doctor's prescription and would authorize doctors to prescribe, prepare, dispense, and administer laetrile.

In voting to remove the prescription requirement from the bill, the Commission stated that since laetrile is not a drug, and has no known medical value, it should be sold over the counter with no physician involvement.

In other action on January 11, the Commission:

- Took no position on AB 321, which prohibits the use of public funds for abortions except in the cases of sexual assault, incest and medical necessity to save the mother's life. The Commission felt the issue was not medical.
- Reviewed new legislation including: AB 1086, which deals with the withholding or withdrawal of extraordinary means of artificial life support from terminally ill persons; SB 633, which calls for equal health insurance coverage for psychologists' services when those services are covered by the contract when rendered by a physician; and a series of amendments proposed by the Department of Health and Social Services which deal with nonsubstantive review to the certificate-of-need law in Wisconsin.
- Agreed to develop a legislative proposal to create a separate, independent Department of Health in Wisconsin. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

CORRECTION: In the membership report of October 17, 1977 in the December 1977 issue of the Journal under the category of NEW MEMBERS, the correct address of Alan Daniel, MD should have been 950 N 12th St, Milwaukee, Wis 53201. The Journal apologizes for any inconvenience the incorrect address may have caused.

Membership Report as of November 12, 1977

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

ASHFIELD-BAYFIELD-IRON

Lind, Robert G, 2101 Beaser Ave, Ashland 54806 (1945, Regular, Diagnostic Radiology/Radiology, Certified-R)
Sandin, Howard N V, 2101 Beaser Ave, Ashland 54806 (1947, Regular, Obstetrics and Gynecology)
Vernier, Edward M, 2101 Beaser Ave, Ashland 54806 (1944, Regular, Obstetrics and Gynecology)

BARRON-WASHBURN-BURNETT

Dunne, Morgan G, Box 111A, Rt #1, Star Prairie 54026 (1949, Regular, Diagnostic Radiology/Radiology, Certified-R)
Youngren, Thomas R, PO Box 127, Cumberland 54829 (1948, Regular, Family Physician)

BROWN

Brusky, Alvin Henry, 101 N Washington St, Green Bay 54301 (1906, AMA Age Exempt, General Surgery)

CHIPPEWA

Henry, Richard A, 2661 County Trunk I, Chippewa Falls 54729 (1947, Regular, Pathology)

DANE

Belzer, Folkert O, 1300 University Ave, Madison 53706 (1930, Regular, General Surgery, Certified)
Bourque, Adrian R, 6330 Putnam Rd, Madison 53711 (1932, Resident, Therapeutic Radiology)
Curreri, Anthony R, 2500 Overlook Terr, Madison 53703 (1909, Regular, General Surgery/Thoracic Surgery, Certified-GS)
Danahy, Daniel, 37 Oxwood Circle, Madison 53717 (1943, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)
Erskine, C Peter, 465 WARF, 610 Walnut St, Madison 53706 (1947, Regular, Pediatrics/Emergency Medicine)
Goodman, George B, 1300 University Ave, Madison 53706 (1951, Resident, Internal Medicine)
Guthrie, Stephen D, 4125 Mandan Crescent, Madison 53711 (1945, Resident, General Surgery)
Lange, Thomas A, 1300 University Ave, Madison 53706 (1942, Regular, Orthopedic Surgery, Certified)
Lari, Steven J, 427 Lorch St, Madison 53706 (1949, Resident, Psychiatry)
Lemke, Bradley N, 1300 University Ave, Madison 53706 (1948, Resident, Ophthalmology)
McDonald, Robert A, 1313 Fish Hatchery Rd, Madison 53715 (1948, Regular, Dermatology)
Narsete, Thomas A, 1102 Starlight Dr, Madison 53711 (1949, Resident, General Surgery)
Olson, Janet E, 5226 Meadowood Dr, Madison 53711 (1947, Resident, Family Physician)
Pietan, Jerald H, 7833 Oxtrail Way, Verona 53593 (1941, Regular, Radiology, Certified)
Slavic-Svircev, Vera, 1300 University Ave, Madison 53706 (1946, Resident, Anesthesiology)

DOUGLAS

Al-Azem, Mohamed W, 3500 Tower Ave, Superior 54880 (1947, Regular, Radiology/Nuclear Medicine)
Lao, Antonio L, 3600 Tower Ave, Superior 54880 (1942, Regular, Internal Medicine)

EAU CLAIRE-DUNN-PEPIN

Hogue, David K, 2125 Heights Dr, Eau Claire 54701 (1944, Regular, Ophthalmology, Certified)

GREEN

Breadon, George E, 1515 10th St, Monroe 53566 (1943, Regular, Otorhinolaryngology)
Davis, Carleton B, Jr, Rte #1, Box 133B, Monticello 53570 (1944, Regular, Gastroenterology/Internal Medicine, Certified-IM)
De Waal, Jan G, 2015 26th St, Monroe 53566 (1930, Regular, Orthopedic Surgery, Certified)
Dimartini, Joseph J, 1515 10th St, Monroe 53566 (1941, Regular, Urology)
Paul, Marie M, 2649 6th St, Monroe 53566 (1942, Regular, Anesthesiology)
Salanova, Vicenta, 817 15th Ave, Monroe 53566 (1945, Regular, Neurology)

GREEN LAKE-WAUSHARA

Osicka, Steve R, PO Box 336, Redgranite 54970 (1918, Regular, Family Physician, Certified)

LACROSSE

Terhorst, Thomas R, 709 S 10th St, LaCrosse 54601 (1944, Regular, Radiology, Certified)

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LANGLADE

Reinardy, Michael J, 837 Clermont St, Antigo 54409 (1940, Regular, Family Physicians, Certified)

MARINETTE-FLORENCE

Caselton, Stephen C, 2153 Riverside Ave, Marinette 54143 (1945, Regular, Pediatrics)
Hoyme, Steven H, 801 Wells St, Marinette 54143 (1945, Regular, Ophthalmology, Certified)
Mack, Thomas V, 2500 Hall Ave, Marinette 54143 (1950, Regular, Family Physician)

ONEIDA-VILAS

Saunders, Reynolds J, 56 S Brown, Rhinelander 54501 (1945, Regular, Anesthesiology)
Steidl, Richard M, 1044 Kabel Ave, Rhinelander 54501 (1927, Regular, Clinical Pathology/Pathology)
Wiesner, James K, PO Box 549, Woodruff 54568 (1948, Regular, Internal Medicine)

PORTAGE

Gauder, John P, 2501 Main St, Stevens Point 54481 (1947, Regular, Internal Medicine, Certified)
Hendrickson, David J, 900 Illinois Ave, Stevens Point 54481 (1946, Regular, Emergency Medicine)
Johnson, Donald D, 1800 N Point Dr, Stevens Point 54481 (1934, Regular, General Practice)
Schneeberger, E M, 2501 Main St, Stevens Point 54481 (1948, Regular, Internal Medicine)

PRICE-TAYLOR

Hanson, Rolf C, 605 Peterson Dr, Phillips 54555 (1948, Regular, Family Physician)
Oliveros, Danilo E, 101 N Gibson Ave, Medford 54451 (1941, Regular, General Practice)

RACINE

Palm, Robert A, 2405 Northwestern Ave, Racine 53404 (1940, Regular, Urology)

RUSK

Desbiens, Norman A, 906 College Ave, West, Ladysmith 54848 (1946, Regular, Internal Medicine, Certified)
Hackney, Robert (DO), 906 College Ave, West, Ladysmith 54848 (1943, Regular, Internal Medicine/Gastroenterology, Certified-IM)
Johnson, Raymond R, 906 College Ave, West, Ladysmith 54848 (1947, Regular, Pediatrics)
Madsen, James E, 906 College Ave, West, Ladysmith 54848 (1948, Regular, Family Physician)
Naley, Rolf K, 906 College Ave, West, Ladysmith 54848 (1948, Regular, Family Physician)

SAUK

Damos, James R, 1900 N Dewey Ave, Reedsburg 53959 (1947, Regular, Family Physician)
De Giovanni, John A, 55 Prairie Ave, Prairie du Sac 53578 (1947, Regular, General Surgery)
Schofeld, Michael R, 1900 N Dewey Ave, Reedsburg 53959 (1948, Regular, Family Physician)

WINNEBAGO

Fox, Thomas P, 411 Lincoln St, Neenah 54956 (1945, Regular, Internal Medicine, Certified)
Wilson, Edwin E, 411 Lincoln St, Neenah 54956 (1948, Regular, Internal Medicine)

WOOD

Dhru, Dhavalkirti S, 1000 N Oak Ave, Marshfield 54449 (1943, Regular, Otorhinolaryngology)
Kirchner, John P, 402 Park St, Marshfield 54449 (1940, Regular, Gastroenterology/Internal Medicine, Certified-IM)
Kryda, Michael J, 1000 N Oak Ave, Marshfield 54449 (1946, Regular, Internal Medicine, Certified)
Leer, Richard A, 1000 N Oak Ave, Marshfield 54449 (1945, Regular, Family Physician, Certified)
McConnell, Rex A, 1000 N Oak Ave, Marshfield 54449 (1931, Regular, Emergency Medicine)
Page, Robert W, 1610 Felker Ave, Marshfield 54449 (1946, Regular, Neurology)
Peterson, Douglas B, 1000 N Oak Avenue, Marshfield 54449 (1943, Regular, Internal Medicine)
Rhodes, Ross A, 1001 W Upham St, Marshfield 54449 (1943, Regular, Gastroenterology/Internal Medicine, Certified-IM)
Tarabishi, M Hisham, 1000 N Oak Ave, Marshfield 54449 (1939, Regular, Otorhinolaryngology)
Watson, Linley E, 1000 N Oak Ave, Marshfield 54449 (1941, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BROWN

Nicolaus, William H, Alexandria, Va, to 300 East Brandon Rd, Columbia, Mo 65201

COLUMBIA-MARQUETTE-ADAMS

Weihe, Arthur R, Friendship, to 216 Alicia Lane, Biloxi, Miss 39531

DANE

Cooper, Garrett A, Madison, to 301 Circulo Pladins, Green Valley, AZ 85614
Koch, John J, Verona, to 55 Prairie Ave, Prairie du Sac 53578
Schoenenberger, A P, Madison, to 6921 Birdie Way, Ft Myers, FL 33901

EAU CLAIRE-DUNN-PEPIN

Cameron, William G, Eau Claire, to 250 Palmer Blvd, North Fort Myers, FL 33903

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LACROSSE

Arani, Ali G, LaCrosse, to 411 W Wyoming Ave, Cincinnati, OH 45215

MANITOWOC

Radl, Cyril J, Scottsdale, Az, to 1425 North 9th St, Manitowoc 54220

MARATHON

Kamat, Pandurang V, Minneapolis, to 4141 Briarwood Ave, Wausau 54401

MILWAUKEE

Kassowitz, Karl E, Boulder, Colo, to 3321 N Summit Ave, Milwaukee 53211

Nemeth, Charles, Waupun, to PO Box 185, Helmutt, NY 14079

OUTAGAMIE

Miller, Ernest J, Appleton, to 5409 South Blake Rd, Edina, Minn 55436

PIERCE-ST CROIX

Kiernan, John H, Hudson, to 6049 Linden Rd, St Paul, Minn 55119

RACINE

Hirsh, S Jay, Springfield, Pa, to 2405 Northwestern Ave, Racine 53404

Kolmeier, Karl H, Racine, to 1716 Durrett Cove, Dunwoody, Ga 30338

SAWYER

Callaghan, Desmond H, Hayward, to 203 Parliament Dr, Horseshoe Bend, Ark 72512

SHEBOYGAN

Kovacic, Joseph F, Sheboygan, to 1155 Oleander Dr, Naples, Fl 33940

WOOD

Tan, Thien S, Marshfield, to VA Hospital, Butler, Pa 16001

DEATHS

Aszman, Paul E, Milwaukee County, May 1977

Gloss, Albert J, Waupaca County, June 2, 1977

Andrews, George R, Marathon County, Nov 3, 1977

Byrne, Robert W, Milwaukee County, Nov 10, 1977

Garrison, Rogers E, Wood County, Nov 10, 1977

Peters, Leo M, Milwaukee County, Nov 10, 1977

Dunker, George O, Milwaukee County, Nov 14, 1977

Reuter, Maurice J Jr, Milwaukee County, Nov 15, 1977

Simons, Neal S, Trempealeau-Jackson-Buffalo County, Nov 15, 1977

Sydow, Herbert F I, Waukesha County, Dec 1, 1977

Hannan, Kenneth D L, Sauk County, Dec 10, 1977

Davidoff, David E, Milwaukee County, Dec 15, 1977

Heidner, Frederick C, Milwaukee County, Dec 17, 1977

Mason, Robert, Wood County, Dec 21, 1977 ■

OBITUARIES

◈County, State, AMA Members

◈ **Paul Eric Aszman, MD,** 80, Milwaukee, died May 1977 in Miami, Fla. Born Feb 23, 1897 in Portage, Doctor Aszman graduated from Marquette University School of Medicine in 1929. He had been living in Florida since 1954.

◈ **Albert John Gloss, MD,** 77, former Fremont physician, died June 2, 1977 in Bensenville, Ill. Born Dec 21, 1899 in Budapest, Hungary, Doctor Gloss graduated from Loyola Medical School, Chicago, Ill, in 1933. Surviving is his widow, Dorothy; a daughter, Mrs Clifford (Mary) Keating, Appleton, and a son, Paul, San Francisco, Calif.

◈ **George R Andrews, MD,** 62, Wausau, died Oct 31, 1977 in Wausau. Born Aug 28, 1915 in Durham, NC, Doctor Andrews graduated from Duke University Medical School. Surviving are his widow; two sons, Reid Andrews III, Lawrence, Mass, and Douglas, Wausau; and a daughter, Alison of Wausau.

◈ **Robert William Byrne, MD,** 62, Mequon, former chairman of the Department of Radiology at Columbia Hospital, Milwaukee, died Nov 10, 1977 in Milwaukee. Born Nov 7. 1915 in Crookston, Minn, Doctor Byrne graduated from the University of Michigan Medical School in 1940. He served in the United States Army Medical Corps during World War II from 1941 - 1946. He held offices in a number of state and local radiologic and medical organizations, and served as a councilor from Wisconsin of the Radiological Society of North America. Surviving are his widow, Carolyn; two daughters, Mrs Michael (Lynne) Kreig, Milwaukee, and Mrs Herbert (Marsha) Feyer, Royal Oak, Mich; and a son, Robert B of Cedarburg.

◈ **Leo Michael Peters, MD,** 71, Milwaukee, died Nov 10, 1977 in Milwaukee. Born Oct. 31, 1906 in Dedham, Iowa, Doctor Peters graduated from Marquette University School of Medicine in 1931 and did postgraduate work in surgery for several years at Polyclinic Hospital in New York City. He was a member of the medical staff of Milwaukee's Deaconess Hospital, and served positions as secretary-treasurer and president, and was on its building committee. Surviving are his widow, Cecelia; one daughter, Mrs Diane L Schulz; and three sons, Leo M, William J, and Thomas F.

◈ **George O Dunker, MD,** 70, Fox Point, died Nov 14, 1977 in Wood, Wis. Born Sept 28, 1907 in Milwaukee, Doctor Dunker graduated from Marquette University School of Medicine in 1931. An ophthalmologist in the Milwaukee area for more than 45 years, he retired from medical practice in 1976. Doctor Dunker served in the United States Army Medical Corps during World War II. He was on the medical staffs of St. Joseph's and West Allis Memorial hospitals. Surviving are his widow, Constance; two daughters, Mrs Charles (Peggy) Wunsch, Fox Point and Mrs Harold (Virginia) Mueller III of Richland Center; and two sons, Stephen, Bayfield, and Thomas of New York City.

◈ **Maurice J Reuter Jr, MD,** 48, Glendale, died Nov 15, 1977 in Glendale. Born Dec 20, 1928 in Rochester, Minn, Doctor Reuter graduated from Marquette University School of Medicine in 1955. He was on the medical staffs of Deaconess, Family, and Lutheran hospitals, and headed the medical staff of St Anthony Hospital from 1971-1973. He also served in the United States Air Force's medical corps for several years. Surviving are his widow, Sally; and two sons, Maurice III and Lee, both at home.

◈ **Herbert F Sydow, MD,** 81, Waukesha, died Dec 1, 1977 in Waukesha. Born Sept 2, 1896 in West Bend, Doctor Sydow graduated from Northwestern University Medical School in 1922. Doctor Sydow served as chief-of-staff at Waukesha Memorial Hospital in 1945-47, 1950-53, and 1958-59. Surviving are his widow, Mary, and a daughter, Mrs Robert (Jean) West of Milwaukee.

◈ **Edwin L Everts, MD,** 76, Hales Corners, died Dec 10, 1977 in Milwaukee. Born Oct 21, 1901, Doctor Everts graduated from Marquette University School of Medicine in 1928. Doctor Everts retired from medical practice in 1970.

◈ **Kenneth Douglas Hannan, MD,** 67, Baraboo, died Dec 10, 1977 in Baraboo. Born May 8, 1910 in Green Bay, Doctor Hannan graduated from the University of Wisconsin Medical School, Madison, in 1935, and had practiced in Baraboo for 30 years before retiring in 1975. Surviving are his widow, June; two daughters, Barbara Ann, Winona, Minn, and Patricia Ann of Jefferson.

◈ **Robert Walter Mason, MD,** 67, Marshfield, died Dec 21, 1977 in Marshfield. Born July 19, 1910 in Marshfield, Doctor Mason graduated from the University of Wisconsin Medical School, Madison, in 1934. Doctor Mason became associated with the Marshfield Clinic in 1936 after serving his residency in orthopedics at Milwaukee County General Hospital. Doctor Mason served as vice-president of the Marshfield Clinic and for many years served on its executive committee. Doctor Mason served as a councilor of the State Medical Society of Wisconsin from 1959-1965 and also served as president and secretary of Wood County Medical Society.

Surviving are his widow, Lorraine; and three sons, Robert, Marshfield; Thomas, Leverett, Mass; and James of Salt Lake City. ■

Even brilliant surgery can be complicated by infection...

Dr Donald Fullerton, left, University of Wisconsin Medical School associate dean of clinical affairs, with past and present commanders of the 44th General Hospital. Front row, left: Dr James Brandenburg, otolaryngology chairman and current commander; previous commanders Dr Bruce Longley, associate professor of surgery; Dr Leroy Sims, professor of medicine. Back row from left are past commanders Dr Frank L Weston, emeritus clinical professor of medicine; Dr Herman Shapiro, emeritus clinical professor of medicine; Dr Anthony R Curreri, professor of surgery; and Madison dentist Dr C A Gjertson. (Photo courtesy WISCONSIN MEDICAL ALUMNI QUARTERLY)

44th General Hospital

. . . Late last summer the University of Wisconsin Medical School, Madison, renewed its affiliation agreement with the United States Reserve 44th General Hospital.

Like many other army hospitals and medical schools, the initial agreement was made in 1953. However, its links go back to 1940 and the efforts of Dean William S Middleton. In those early war days the professional personnel for the hospital unit was picked from the medical school faculty and its statewide preceptorial staff.

The hospital was activated as a complete unit in 1943. After initial training the group was sent to Australia and a year later was moved to Leyte in the Philippine Islands. There Col Frank L Weston became commanding officer of the 44th. Unlike most general hospitals, the 44th functioned both as a hospital and combat outfit. Details of the 44th's war activities appeared in the *Wisconsin Medical Journal*, November 1976, bicentennial series, by Dr Herman H Shapiro.

The unit was officially deactivated on April 15, 1946 but reactivated as a reserve unit in 1948 as trouble brewed in Southeast Asia. The reservists included a small nucleus of the inactive World War II group, including one nurse, Lola Reddeman, Dr Einar R Daniels,* practicing in Milwaukee, Dr Chester A Gjertson, a Madison dental officer, and Doctors J Leroy Sims, Herman H Shapiro, and Anthony R Curreri* of the Madison Faculty. In 1976 Doctor Gjertson ended his term as commanding officer, the last of the World War II 44th personnel.

The 44th, however, remains the bulwark of Wisconsin's contribution to medicine's citizen soldiers. ■

PHYSICIAN BRIEFS

Ronny W Wenang, MD*

. . . Hartford, has become associated with the Jackson Medical Service Corporation and Parkview Medical Associates, Ltd, in the practice of obstetrics and gynecology. A graduate from the Pajajaran State University Medical School, Bandung, Indonesia, Doctor Wenang completed a rotating internship and practiced general medicine in Bandung prior to coming to the United States. He completed his residency in obstetrics and gynecology at Presbyterian Hospital, University of Pennsylvania Medical Center.

John J Tordoff, MD*

. . . Janesville, recently was reelected chief-of-staff of Mercy Hospital. Doctor Tordoff has been a member of the medical staff since 1953. MDs Thomas Sargeant, member of the medical staff since 1960, is president of the staff; Nicholas G Papadakcs,* member of the staff since 1968, was named president-elect; and Stephen C Werner,* staff member since 1975, was reelected secretary-treasurer.

Edward P McAuliffe, MD*

. . . Sturgeon Bay, has been elected chief-of-staff of Door County Memorial Hospital. A native of Chicago and graduate of Loyola University School of Medicine, Doctor McAuliffe is affiliated with the Door County Medical Center.

John R Mills, MD*

. . . Green Bay, has left to join the Projcct HOPE medical education program in Trujillo, Peru. Doctor Mills, an otolaryngologist, will help set up an ear, nose, and throat specialty curriculum for medical students at the National University in Trujillo, northern Peruvian capital. Doctor Mills is a graduate of the Univcrsity of Illinois Medical School. He has been an assistant professor of otolaryngology at the University of Wisconsin since 1968.

Ihor Galarnyk, MD*

. . . Plain, vice-chief of the medical staff of Sauk-Prairie Memorial Hospital, recently was elected to membership on the Health Planning Council (HPC) board of directors. He also was elected to a one-year term on the executive committee.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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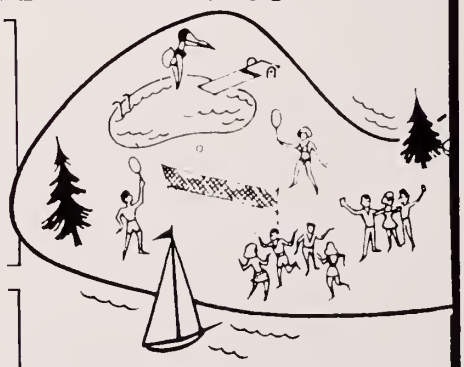

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Carlos C Yu, MD*

. . . New London, recently was elected president of the medical staff of New London Community Hospital. Other MDs elected are: Lloyd P Maasch,* Weyauwega, vice-president; and Luis Galang,* New London, secretary-treasurer.

William D James, MD*

. . . Oconomowoc, recently was appointed to Congressman Robert Kasten's Ninth District Congressional Appointments Commission. Doctor James joins a 17-member commission, formed by Robert Kasten in 1975, which recommends young men and women for nominations to US service academies. Doctor James, past president of the State Medical Society, has been medical director of the Masonic Home, Dousman, since retiring from his medical practice in Oconomowoc in 1972.

Gerald E Porter, MD*

. . . Marshfield, recently was elected president of the Marshfield Clinic succeeding Ben Lawton, MD.* Doctor Porter, a pediatrician, had been vice-president. Named to succeed Doctor Porter as vice-president was Nelson A Moffatt, MD.* John P Parker, MD,* was elected secretary succeeding William J Maurer, MD,* and Charles E Sampson Jr, MD* was elected treasurer succeeding Doctor Moffatt.

Doctor Porter became affiliated with the Clinic in 1963 and is a graduate of the University of Wisconsin Medical School. He also is a clinical pediatric instructor at the Medical School and is a recognized authority on the issue of child abuse.

Mark Gibson, MD

. . . Marshfield, recently became associated with the Department of Internal Medicine of the Marshfield Clinic. He graduated from the University of Illinois School of Medicine and served his internship and residency at Mary Imogene Bassett Hospital, Cooperstown, New York. He also completed an emergency medicine residency at Royal Victoria Hospital, McGill University, Montreal, Canada. Prior to joining the Marshfield Clinic, Doctor Gibson held the post of chief-of-emergency services at Malcolm Grow Hospital, Andrews Air Force Base, Washington, DC.

Carl M Curtiss, MD

. . . recently became a member of the Manitowoc Clinic. A 1972 graduate from Ohio State University School of Medicine, he served his internship and residency at University of Minnesota Hospitals. A fellowship in cardiology also was completed at the University of Minnesota Hospitals. He is a diplomate of the American Board of Internal Medicine.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1978

3 Dane County Medical Society Board of Trustees
4 Health Care Coalition
5 Surgery Study Committee
5 Task Force on Health Screening and Immunization
9 Dane County Medical Society HMP Committee
10 SMS Committee on Evaluation of Delivery and Cost of Medical Care
10 Dane County Medical Society General Membership Meeting
11 SMS Committee on Federal Legislation
11 SMS Commission on Governmental Affairs
11 WisPRO Advisory Group
11 WHCRI Medical Quality of Care Committee
13 Subcommittee on Accreditation
13 WisPRO Long-Term Care Committee
16 Madison Orthopedic Society
17 Ad Hoc Committee on Physical Therapy
18 WisPRO Executive Committee-Board of Control
18 SMS Section on Ophthalmology Executive Committee
19 SMS Commission on Public Information
19 Ad Hoc Committee to Study Quality Care Activities
19 Medical Defense Committee
19 Uniform Claim Form
20 SMS Physicians Alliance Commission
20 Continuing Medical Education Club (Wisconsin)
20 Legislative Committee-Wisconsin Public Health Association
23 Madison Obstetrics and Gynecology Society
24 SMS Committee on Evaluation of Delivery and Cost of Medical Care
31 SMS Committee on Safe Transportation

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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SERVING SOUTHERN-CENTRAL WISCONSIN

J Lawrence Stoune, MD

. . . Manitowoc, recently was appointed city health commissioner to succeed Russell G Strong, MD* who retired. Doctor Stoune, who has an internal medicine practice in Manitowoc, is a graduate of St Louis University Medical School and also served two years in the United States Air Force.

Richard D Sautter, MD*

. . . has been appointed executive director of Marshfield Medical Foundation. He replaces Frederick J Wenzel who became executive director of Marshfield Clinic September 1, 1976. Mr Wenzel had served in both capacities while a successor was sought for the foundation. Doctor Sautter has been a cardiovascular surgeon at Marshfield Clinic since 1961 and in his new position will continue a limited practice in surgery. He also has been director of medical education at the clinic since October 1975. Doctor Sautter also is a member of the *Wisconsin Medical Journal's* Editorial Board. Doctor Sautter has been closely identified with the Marshfield Medical Foundation in his role as medical director of the Physicians Assistant Training Program. Marshfield Medical Foundation has been engaged in medical research, education, and community service since its formation by a group of clinic personnel in 1959.

Pamela M Beranek, MD
Gary O N Iverson, MD

. . . recently joined the multispecialty clinic of Medical Associates of Menomonee Falls. Doctor Beranek, a family physician, graduated from the University of Iowa Medical School and had been a member of the student health department at University of Wisconsin, LaCrosse, and also the director of sports medicine at the University. Doctor Iverson, a specialist in internal medicine, graduated from the University of Wisconsin Medical School, Madison, and previously had been associated with the Gundersen Clinic Ltd-Lutheran Hospital in LaGrosse.

William R Hiatt, MD

. . . Woodruff, one of the founders of Lakeland Medical Associates, retired from active practice in January. Doctor Hiatt, senior member of the Lakeland Medical Associates Clinic medical staff, graduated from Indiana University Medical School and came to the Lakeland area in 1955.

Donald B Comin, MD*

. . . LaCrosse, recently was reelected president of Skemp-Grandview Clinic. Doctor Comin also was elected president of an ad hoc committee overseeing the merger of Skemp-Grandview Clinic and LaCrosse Clinic. He is a graduate of Western Reserve University, Cleveland, and is chief of internal medicine at St Francis Hospital in LaCrosse.

Klavs Kazaks, MD

. . . a native of Latvia, has joined the Department of Radiology at Gundersen Clinic Ltd-Lutheran Hospital. He received his medical degree from Queens' University, Kingston, Ontario, in 1973 and served his internship at Kingston General Hospital. His residency in radiology was taken at Toronto General Hospital in Canada.

Joseph A Bodensteiner, MD*

. . . Rhinelander, recently was inducted as a fellow in the American College of Surgeons. A member of the Bump Medical Group, Rhinelander, since 1974, Doctor Bodensteiner graduated from the University of Iowa Medical School and interned at Los Angeles County, University of Southern California Medical Center. He served two years in the United States Air Force and returned to the University of Iowa for four years of surgical residency.

Robert M Paster, MD

. . . recently became associated with MDs Lloyd S Kellogg* and Franklin N Dukerschein* in the practice of family medicine at the Oregon Clinic. Doctor Paster graduated from the University of Illinois Medical School and completed his internship at Dalhousie University, Nova Scotia, Canada. ■

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EMERGENCY PHYSICIAN OR physicians—to provide 24-hour coverage for busy emergency room in modern 102-bed general hospital located in the South Central Wisconsin scenic camping and resort area during the tourist season of June, July, and August. Fee for service with a monthly guarantee preferred; other arrangements may be possible. Previous physicians in this capacity have realized $4,000 or more per month; Wisconsin licensure required. Contact Dept 454 in care of the Journal. 1-2/78

GREEN BAY, WISCONSIN—AN excellent opportunity is available for a family practice physician in the Green Bay, Wisconsin area. A younger family practice resident, or general practitioner with some experience is desired. New office setting is in close proximity of a family practice oriented hospital facility. Association and practice arrangements flexible. Contact: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. 1-2/78

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GREEN BAY. OPPORTUNITY FOR a primary care internist or family physician to join a 3-man group. Full partnership available second year. Contact: John Brusky, MD, 1203 S Military Ave, Green Bay, Wis 54304. Tel: 414/494-4781. 1tfn/78

INTERNIST AND PEDIATRICIAN —Unique practice arrangement available with other medical specialists in Medical Arts Building, Sheboygan, Wis. Sheboygan offers excellent hospital facilities in addition to excellent family environment; located on the shores of Lake Michigan. For further information contact: William G Wagner, MD, 1226 North 8th St, Sheboygan, Wis 53051. 2tfn/78

CARDIOLOGIST WITH TRAINING in Echo cardiology, to join a 38-man multispecialty group located in college community of 48,000 with excellent hospital facilities. For further information, contact G E Owen, MD, Midelfort Clinic, Eau Claire, Wis 54701. 2-4/78

AVIATION AND NUCLEAR MEDIcine—Other specialties also needed, $33,500 or higher starting salary based on qualifications and experience, plus noncontributory retirement plan, malpractice insurance paid. and full healthcare benefits. East and West coast locations. Please write to L G Tenneson, NRD, 611 N Broadway, Milwaukee, Wis 53202. 1-12/78

YOUNG FAMILY PRACTICE CLINic—two 33-year-old FPs seeking 3rd and 4th partners. Located 20 miles from East St Paul in St Croix Valley. Expanding community with stable 50-bed hospital. New Clinic with clinic policy being strictly Family Practice oriented. Call T G Domino, MD or S A Lindahl, MD at 715/386-9381, Hudson, Wisconsin. 1tfn/78

TWO FAMILY PRACTITIONERS for new clinic. 36-bed general hospital, count seat population 5.000-6.000. Excellent salary or guarantee. Also locum tenens and emergency room, June, July and August. Guarantee and salary incentive within one and one-half hours of all major Wisconsin cities. Contact: Len Bielinski, 414/787-3357. 2-5/78

TEXAS - SUNBELT PHYSICIAN Placement Service, 5500 N Braeswood, No 177, Houston. Tx 77096 (713) 729-6068 (SUNBELT has a full time MD Director, experienced in active private practice, to assist with finding desired location.) No fee or obligation to the relocating physician. p2/78

WAUWATOSA OFFICE OF RETIRing GP immediately available. Three examining rooms, consultation, treatment and waiting room. Excellent opportunity to take over established active practice, or specialize; purchase equipment and employ present receptionist. $250 per month includes heat, light, air conditioning, and adjacent 20-car free parking. Log Cabin Medical Center, 2515 Wauwatosa Ave., 52313. Tel: 414/453-0611. 1tfn/78*

MEDICAL FACILITIES

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

NEW MEDICAL-DENTAL OFfices for lease: Opportunity to plan and design your new office. Designs for offices 650 to 4000 square feet. Spacious, modern facility now available in convenient Hales Corners. For appointment call 414/271-5017. p12/77,1-2/78

FOR SALE: OFFICE AND MEDIcal equipment of deceased doctor who was engaged in general practice and surgery in the Village of Waterford, Racine County, Wis. Call: 414/539-2868. gltfn/78

FOR RENT: OFFICE SPACE USED by general practitioner prior to his death in the Village of Waterford, Racine County, Wis. Call: 414/539-2868. gltfn/78

FOR LEASE: 4611 N OAKLAND Ave, Milwaukee, (Whitefish Bay-Shorewood). 2400 square feet first floor with entrance ramp, custom built for physician's office. Many extra features, carpeting, drapes, view boxes, dictaphone system, two lavatories, central air conditioning. Call: 414/964-8670, evenings 414/962-6376. 1-2/78

OFFICE SPACE AVAILABLE: New professional building—West Bend, Wis. 30 miles north of Milwaukee. Located directly across from only hospital in area. Individual offices presently occupied by two orthopedic surgeons, one ophthalmologist, one OB/GYN, one family practice group (4 MDs), three dentists, and pharmacy. Two suites available—1200 sq ft and 800 sq ft. Will develop to your requirements. Ideal for any medical specialty—internist, surgeon, dermatologist, urologist, pediatrician, etc. Write or call: Management Committee, Oakbrook Medical Complex, 1201 Oak St, West Bend, Wis 53095. % R. H. Schacht, DDS, 414/334-5151. 12/77,1/78*

PUBLICATIONS

Guide to Biomedical Standards, 1978-1979, sixth edition, 70 pages, can be ordered for $8.00 from: Quest Publishing Co, PO Box 4141, Diamond Bar, Calif 91765. Authoritative directory to over 1,000 standards that regulate medical products or equipment.

Registered Nurses, Descriptive Statistics, 1977, is now available from: Bureau of Health Statistics, PO Box 309, Madison, Wis 53701. Three state agencies have cooperated to gather and analyze the information for this second report which was made possible through the cooperation of Wisconsin's registered nurses, who provided the information with their license renewals for 1977.

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CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 Wisconsin

Mar 10: *A Workshop on Aging*, sponsored by Medical College of Wisconsin, Department of Psychiatry and Mental Health Sciences with Department of Family Medicine and Milwaukee County Mental Health Center, at Sheraton Mayfair Motor Inn, Milwaukee. For Primary Care Physicians, Psychiatrist, and Allied Mental Health Specialists with an interest in aging. Meets criteria for 7 credit hours in Category I of the Physicians Recognition Award of AMA. Fee: $12/person. Check payable to: Medical College of Wisconsin; further info: Ms Betsy Collins, Dept of Psychiatry, 9191 Watertown Plank Road, Milwaukee, Wis 53226; phone 414/257-7227.

Mar 30-Apr 1: Second Annual *Ophthalmology Current Concepts Seminar '78* of the University of Wisconsin-Madison. Lectures and workshops. Sponsored by the Dept of Ophthalmology Faculty, University Hospitals, Madison; at The Wisconsin Center, Madison. Info: Mrs Margaret Kelm, UW Hospitals, 1300 University Ave, Madison, Wis 53706.

Apr 1: Tenth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee, Wis. See details in box elsewhere in this issue.

Apr 5: *Head and Neck Cancer Regional Conference*, St Mary's Hospital, Racine. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705. Details in box elsewhere in this section.

Apr 6: *Head and Neck Cancer Regional Conference*, Beloit Memorial Hospital Beloit. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705. Details in box elsewhere in this section.

Apr 6-27: *Diabetes* lectures around the state.

Apr 13-15: SMS Annual Meeting, MECCA, Milwaukee. Headquarters Hotel: Marc Plaza.

Apr 17-June 6: *Independent Study Course in Immunodeficiency Diseases*, by University of Wisconsin Medical School. 26 hours of Category I credit for AMA-PRA. Info: R H Hansen, Continuing Medical Education, 446 WARF Bldg, 610 N Walnut St, Madison, Wis 53706.

Apr 20: *Head and Neck Cancer Regional Conference*, Sheboygan Memorial Hospital, Sheboygan. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705. Details in box elsewhere in this section.

Apr 28: *Pediatric Anesthesia*, LaCrosse.

Apr 28-29: *Wisconsin Psychiatric Association Annual Scientific Meeting*, at Marshfield Clinic, Marshfield. Friday program: Medical and Psychiatric Utilization of Services. Saturday: Behavorial Change From Four Viewpoints. 10 hours of Category I CEC.

May: Spring Meeting, Wisconsin Neurological Society.

41st Annual
New Orleans Graduate Medical Assembly

March 31 - April 4, 1978

Meeting Theme:
The High Risk Patient

Accreditation:
AMA-Category I/AAFP, ACEP

Program Director:
Oliver H Dabazies Jr, MD FACS

Fee: $200 nonmember physicians. Military: $100. Students, residents, interns and fellows: complimentary registration.

Write or phone:
New Orleans Graduate Medical Assembly, Room 1538 Tulane Medical Center, 1430 Tulane Ave, New Orleans, La 70112; 504/525-9930. 11-12/77, 1-2/78

May 11-13: *Heart Disease and Rehabilitation: State of the Art 1978* at Marc Plaza Hotel, Milwaukee. Sponsored by Cardiovascular Disease Section of Mt Sinai Medical Center, Wisconsin Heart Association and University of Wisconsin, Milwaukee. Info: Carl Foster, PhD, Dept of Medicine, Cardiovascular Disease Section, Mount Sinai Medical Center, 950 N 12th St, PO Box 342, Milwaukee, Wis 53201.

May 19-20: *Emergency Problems in Pediatrics*, UW-Madison.

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1978 NEIGHBORING

Mar 29-31: *Diagnostic and Therapeutic Advances in Gastroenterology*, American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Apr 7: *Pediatric Challenges*, the sixth annual symposium for primary care physicians, at Minneapolis Children's Health Center, 2525 Chicago Avenue, Minneapolis, Minn 55404 (612/874-6122). Presentations: Adolescent Depression, Early Recognition of Melanoma, Constipation and Soiling, Treatment of Croup, Unexpected Problems at Delivery, and Behavorial Milestones in the Preschool Child. Recognized for six prescribed credits by the American Academy of Family Physicians. g1-3/78

Apr 12-14: *Laboratory Medicine*, American College of Physicians Postgraduate Course, Mayo Clinic and Mayo Foundation, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

May 9-10: *Aging-1978: Political and Economic Realities*, fifth annual series of interdisciplinary conferences for the professional community serving the aging, by the Illinois Association of Homes for the Aging, at Pick Congress Hotel in Chicago. Speakers include nationally recognized authorities in the field of aging, with outstanding expertise and the known capability of getting their message across to a highly diversified professional audience. Geared to all those who work with the aging, including government agency personnel, students, volunteers, staff members of social and community service agencies, physicians, long-term care administrators, housing managers, and the like. Info: Conference Coordinator, IAHA Institute on Aging, 3300 W Peterson Ave, Chicago, Ill 60659; 312/583-9850. g1-4/78

May 10-12: *Nuclear Medicine for the Internist*, American College of Physicians Postgraduate Course, Mayo Clinic and Mayo Foundation, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

May 12-14: *Parathyroid Disorders—Contemporary Medical and Surgical Management*. Course Directors Franklin D Schwartz, MD (Medical) and Louis T Tenta, MD (Surgical). Tuition: $250.00 and $50.00 (residents and Fellows). Inquiries: Medical Education Dept, Saint Joseph Hospital, 2900 N Lake Shore Dr, Chicago, Ill 60657. 312/975-3454. p2-3/78

May 14-16: Eighth annual meeting, Great Plains Organization for Perinatal

Head and Neck Cancer Regional Conferences

The Head and Neck Cancer Network has planned three regional conferences for this spring at **St Mary's Hospital, Racine, April 5; Beloit Memorial Hospital, Beloit, April 6;** and **Sheboygan Memorial Hospital, Sheboygan, April 20.** Each conference will begin at 9:00 am and conclude at 3:15 pm. Faculty for each will be different, but there will be lectures in the morning on the head and neck exam for family practitioners and dentists, and workshops in the afternoon on the head and neck exam and prosthodontistry.

AM		April 5 St Mary's Hospital Racine	April 6 Beloit Memorial Hospital	April 20 Sheboygan Memorial Hospital
9:00	Opening of Conference	Robert W Teplin, MD Otorhinolaryngologist Milwaukee	James H Brandenburg, MD Prof, Surgery & Chrm Div of Otolaryngology UW Center for Health Sciences, Madison	David M Wineinger, MD Otorhinolaryngologist Green Bay
9:15	Signs and Symptoms of Head and Neck Cancer	Robert W Teplin, MD Milwaukee	James H Brandenburg, MD Madison	David M Wineinger, MD Green Bay
9:45	Efficient Methods of Head and Neck Examination	Jerome J Veranth, MD Otorhinolaryngologist Asst Clinical Prof MCW, Racine	John K Scott, MD Otorhinolaryngologist Madison	Paschal A Sciarra, MD Otorhinolaryngologist and Associate Clinical Prof, MCW, Sheboygan
10:30	Radiotherapy Treatment of Head and Neck Cancer Patients	Robert W Edland, MD Radiotherapist, Gundersen Clinic, LaCrosse	Antonio Bosch, MD Prof, Human Oncology and Radiology, UW Center for Health Sciences, Madison	John F Mokrohisky, MD Radiotherapist, St Vincent Hospital, Green Bay
11:15	Prosthodontist's Role in Reconstruction of Head and Neck Cancer Patients	Robert Tang, DDS Prosthodontist Milwaukee	Paul J Correll, DDS Prosthodontist; Consultant for UW Center for Health Sciences, Madison	Robert Tang, DDS Prosthodontist Milwaukee
12:00	Luncheon	AFTERNOON WORKSHOPS: 1:00-3:15 PM		

Each program acceptable for five (5) hours by the American Academy of Family Physicians (AAFP); and meets the criteria for five (5) credit hours in Category I for AMA-PRA; and is accredited as a Continuing Education sponsor by the American Dental Association Continuing Education Registry.

Info: Wisconsin Clinical Cancer Center, 1900 University Avenue, Madison, Wis 53705. Registration $6.00 per session.

Health Care, Radisson South Hotel, Bloomington, Minn. Further details appear elsewhere in this section.

May 22-24: *Multidisciplinary Management of Solid Tumors,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: ACP, 4200 Pine St, Philadelphia, Pa 19104.

May 22-24: *Hematology Update 1978,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

1978 OTHERS

Feb 24-25: *Fourth Annual International Symposium on Psychopharmacology—Depression.* Registration Fee: $60.00. Eleven hours Category I credit and 11 prescribed credit hours—AAFP. Contact: Herman C B Denber, MD, University of Louisville School of Medicine, Health Sciences Center, Louisville, Ky 40232. 1-2/78

Mar 6-17: Mediclinics Postgraduate Medical Refresher Course, Fort Lauderdale, Fla. 50 Hours credit AAFP. Info: Mediclinics, 832 Central Medical Bldg, St Paul, Minn 55104.

Apr 1-6: *American College of Allergists 34th Annual Congress,* at Las Vegas Hilton Hotel, Las Vegas, Nev. Comprehensive review of clinical immunologic and allergic diseases relevant to the needs of the physician in practice. The 5.5-day program will focus on physician/registrant participation. Credit: AMA CME Category I—30 hours. Registration fee: Members—$75, nonmembers—$190. No fee for Residents, Interns, Nurses and Technicians from teaching hospitals presenting letters from department heads. Info: Frances P White, Executive Secretary and Treasurer, American College of Allergists, 2141 Fourteenth St, Boulder, Colo 80302; 303/447-8111. g1-2/78

Apr 10-14: *American Occupational Health Conference* combined annual meetings of American Occupational Medical Association and American Association of Occupational Health Nurses at Fairmont Hotel, New Orleans, La. Info: Howard N Schulz, Conference Manager, American Occupational Health Conference, 150 North Wacker Dr, Chicago, Ill 60606. g2tfn/78

May 19-21: *Medicine of the Whole Person,* sponsored by American Holistic Medicine Association; cospon-

Wisconsin Psychiatric Association Annual Scientific Meeting

April 28-29, 1978/Marshfield Clinic

1000 North Oak Avenue/Marshfield, Wisconsin 54449

Friday, Apr 28: MEDICAL AND PSYCHIATRIC UTILIZATION OF SERVICES

1:30- 1:40 Welcome

1:40- 2:10 *Dr Allen Jacobsen,* Associate Clinical Professor of Psychiatry, Bunker Hill Health Project, Harvard University, Boston, Massachusetts

2:10- 2:40 *Dr Jan Hankins,* Assistant Professor of Sociology, Health Care Services Research Center, Johns Hopkins University, Baltimore, Maryland

2:40- 3:10 *Dr Edwin Hoeper,* Psychiatrist, Marshfield Clinic

3:10- 3:30 Coffee

3:30- 4:15 *Dr Darrell Regier,* Director, Biometry and Epidemiology, National Institute of Mental Health, Rockville, Maryland

4:15- 5:15 Discussion—*Dr Herzel Spiro,* Chairman, Department of Psychiatry, Medical College of Wisconsin, Milwaukee

Saturday, Apr 29: BEHAVIORAL CHANGE FROM 4 VIEWPOINTS

9:00-10:00 *Dr John Davis,* Research Psychiatrist Illinois State Psychiatric Institute, Chicago, Illinois "Psychopharmacology and Behavorial Change"

10:00-10:15 Coffee

10:15-11:15 *Dr David Morrison,* Industrial Psychiatrist, Topeka Kansas

11:30- 1:00 Lunch—Marshfield Clinic Cafeteria

1:00- 2:00 *Dr Maxie Maultsby,* Psychiatrist, University of Kentucky, Lexington
"Behavior Therapy and Behavior Change"

2:00- 2:15 Coffee

2:15- 3:15 *Dr John Weakland,* Mental Research Institute, Palo Alto, California
"Family Therapy and Behavioral Change"

3:15- 4:30 Discussion by each of four presentees. Integration of the four concepts

4:30- 5:00 *Dr Jules Masserman,* Professor of Psychiatry, Northwestern University, Chicago, Illinois

Acceptable for 10 credit hours, Category I

Info: Edwin Hoeper, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wisconsin 54449

Tenth Annual Southeastern Wisconsin Cancer Conference

COLON CANCER

April 1, 1978

Pfister Hotel—Milwaukee Wisconsin

8:00-9:00 am Registration

9:00-9:30 am Harlan J Spjut, MD, Professor of Pathology, Baylor Head of Anatomic Pathology, St Luke's Hospital, Houston, Tex

9:30-10:00 am Frances J Tedesco, MD, Co-Director of Clinical Research Unit, University of Miami, School of Medicine, Miami, Florida

10:00-10:30 am LaSalle Leffall, MD, Professor and Chairman, Department of Surgery, College of Medicine, Howard University, Washington, D C

10:30-11:00 am Coffee

11:00-11:30 am Leonard L Gunderson, MD, Assistant Professor in Radiation Oncology, Massachusetts General Hospital and Harvard Medical School, Boston, Mass

11:30-12:00 n Reginald Pugh, MD, Head of Division of Medical Oncology, Alleghany General Hospital, Pittsburgh, Pa

12:00-12:30 pm Panel Discussion Moderator: John J Gramling, MD, Associate Clinical Professor of Surgery, Medical College of Wisconsin

Credit: 3 Hours of Category I AMA-PRA, also 3 Hours of elective credit by AAFP

Conference Chairman: *Frank E Berridge, MD,* 8430 West Capitol Drive, Milwaukee, Wis 53222.

sored by Biogenic Institutes of America and American Society of Contemporary Medicine and Surgery, at Denver, Colo. Biogenic Institutes of America, Inc (a not-for-profit foundation dedicated to health) certifies that this continuing medical education offering meets the criteria for 9 credit hours in Category I of the AMA Physician's Recognition Award. Contact Biogenic Institutes of America, Inc, Route 2, Welsh Coulee, La-Crosse, Wis 54601; 608/786-0611. g1-4/78

May 22-26: *Review of the Old and New in the Diagnosis of Infectious Diseases,* American College of Physicians Postgraduate Course, Alton Ochsner Medical Foundation, New Orleans, La. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Jun 14-18: *Third Annual Symposium on Lung Disease,* at The Cloister, Sea Island, Georgia. A symposium on the diagnosis and management of lung disease for practicing physicians. Info: Betty Rafshoon, Georgia Lung Association, 1383 Spring Street NW, Atlanta, Ga 30309; 404/876-3601. g1-5/78

1978 AMA

Mar 31-Apr 1: *Regional drug abuse conference: The Physician and Drug Abuse Treatment,* by AMA's Dept of Mental Health, at Water Tower Hyatt Hotel, Chicago. For physicians in Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Registration fee: $50—AMA members, medical society executives, nonphysicians; $100—nonmember physicians; special reduced rates for housestaff and medical students. Category I credit for the AMA-PRA will be given on an hour-for-hour basis. Program: Welcoming remarks by Joseph H Skom, MD, chairman. • Medical Involvement in Drug Abuse. • Attitudinal Barriers: The Physician's, the Patient's, Other Health Personnel. • The Current Drug Scene—The State of Abuse. • Six each Concurrent Workshops and Clinical Seminars: (1) Making Effective Referrals, (2) Relating to Law Enforcement, (3) Improving Prescribing Practices, (4) Working with Non-MD Personnel, (5) Dealing with Polydrug Abuse, and (6) Office-based Treatment; and (1) Adolescent Care, (2) Geriatric Problems, (3) Perinatal Care and Problems, (4) Emergency Room Problems, (5) Psychiatry and Drug Abuse, and (6) The Drug Abuser as a Surgical Patient. • Informal discussion groups: (1) Medical School Education—Career Teachers, (2) Therapeutic Communities, (3) Self-help Groups, (4) Methadone Maintenance, (5) Industrial Programs and (6) Impaired Physician Programs. • Reports from the workshops. • Concurrent State Sessions (Putting conference recommendations to work on the local level; working with single state agencies). g1-2/78

Eighth Annual Meeting

GREAT PLAINS ORGANIZATION FOR PERINATAL HEALTH CARE

Perinatal Care from Community to Center

Sunday-Tuesday, May 14-16, 1978

Radisson South Hotel
Bloomington, Minnesota

Guest Speakers:
Dr Thomas G Baffes—*Perinatal Malpractice from Community to Center*

Dr William J R Daily—*Who Is the Normal Newborn?*

Dr Gregory Grabowski—*Perinatal Genetics for Who and Why?*

Dr Frank Boehm—*Expected Date of Confinement*

Each plenary speaker will present a workshop and the other 18 workshops or panel discussions are planned around both obstetric and neonatal care aspects of perinatal care. Continuing Education credits/cognates have been applied for.

* * *

The Great Plains Organization is composed of nurses, physicians, administrators, social workers, and other professionals interested in improving perinatal care in the six upper midwest states (North and South Dakota, Minnesota, Wisconsin, Iowa, and Nebraska). The Organization is unique in its broad regional approach and perinatal interdisciplinary involvement. GPO's aim is to foster the development and implementation of programs to enhance health care to pregnant women and newborn infants as well as promoting total family involvement in the perinatal process.

* * *

For further information contact Mrs Virginia Rittenour, Coordinator, Great Plains Organization, 420 Delaware St SE, Box 50, Minneapolis, Minn 55455; (612) 373-5718.

CONTRIBUTIONS—CES FOUNDATION
December 1977

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1977.

Unrestricted

James F Bigalow, MD; Gay D Trepanier, MD; Robert J Greischar, MD; Waukesha County Auxiliary; August Jurishica, MD; James J Barrock, MD; Morrison Schroeder, MD; Conrad Giesen, MD; Ear, Nose and Throat Association of Wausau; Thomas J Doyle Jr, MD; Henry J Okagaki, MD; Robert E McMahon, MD; John W Foreman, MD; Robert G Wochos, MD; HJ McGinnis, MD; John H Steiner, MD; John T Bollinger, MD; Denton P Engstrom, MD; Albert F Rogers, MD; Dr-Mrs George A Behnke; John R Larsen, MD; Warner S Bump, MD; William R Kreul Sr, MD; Rafael S Saladar, MD; Etheldred L Schafer, MD; WO Dietsche, MD; JW McDonough, MD; Michael P Mehr, MD; Henry A Settlage, MD; Dr-Mrs Myron Schuster; Chesley P Erwin, MD; William O Meyers, MD; Ruth E Church, MD; Harold H Scudamore, MD; Milton M Bines, MD; Victor S Falk, MD; Marriott T Morrison, MD; Daniel F Johnson, MD; Thomas A Leonard, MD—*Voluntary Contributions*

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Restricted

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Dr-Mrs Richard Edwards—*Karma R Kennedy*
EJ Nordby, MD—*Kenneth D Hannan, MD; Robert Mason, MD*
Mr-Mrs ER Thayer—*Robert Mason, MD*
Mr-Mrs David Hayes; Mrs Edith Hayes; Mr-Mrs LaVerne Johnson—*Joseph Moran* ■

PRIOR AUTHORIZATION REVISIONS

The Bureau of Health Care Financing has made several changes recently in prior authorization policies relating to out-of-state medical services for T-19 Medicaid recipients. Physicians should take note of the following changes:

(1) Beginning February 1, 1978, all nonemergency, out-of-state services shall require prior authorization from the Bureau of Health Care Financing, except where the patient is a resident of a border community and the provider has been granted border status.

(2) When a Wisconsin Medical Assistance recipient is referred to an out-of-state provider who does not have border status, it is the responsibility of the referring physician to obtain prior authorization.

(3) In instances where a recipient suffering from a chronic illness, such as arthritis or diabetes, will be absent from the state for an extended period, the recipient's physician should obtain prior authorization for all services directly related to that illness; *eg*, pharmacy, outpatient treatment. The physician's request should include an indication of the length of time that patient will be absent from the State of Wisconsin and a list of specific services that the patient's condition requires.

NEW STATE LAB BILLING PROCEDURES

The 1977-79 state budget bill passed by the Legislature last June requires a new procedure for billing for tests performed by the State Laboratory of Hygiene. The law requires physicians to identify on the patient or third-party billing statement, the actual amount charged by the State Laboratory of Hygiene for services it performed. The new law does not prohibit a physician from charging a patient or carrier for such services as drawing blood for tests, postage to the State Lab, and handling fees. It *does* require notice of the State Lab charges on the billing statement. The law also includes a $250 penalty for anyone failing to comply with its requirements.

NBC AIRS SPECIAL ON "MEDICINE IN AMERICA"

On January 3, NBC television devoted three hours of prime time programming to a program entitled: "Medicine in America: Life, Death and Dollars." The program presented a fairly balanced view of topics such as: the education of doctors, health-care costs, national health insurance, unnecessary surgery, preventive medicine, and technological advances within the health-care system. In addition, NBC took a random poll of 600 persons and their satisfaction with, and perceptions of, America's health-care system. The results of the poll included the following: When asked if they would consider suing for malpractice—seven percent of the respondents said they would, and 92 percent said they wouldn't; when asked about their feelings toward the medical system in general, 61 percent rated it excellent to good and 35 percent rated it fair to poor; when asked if they thought there was alot of unnecessary surgery performed, 50 percent said yes and 34 percent said no; with 16 percent having no opinion.

The SMS Communications Department in Madison, along with SMS field staff and the SMS Public Information Commission set up health-care provider reaction programs to the NBC special at local levels. Such reaction programs took place on January 3 at WEAU-TV in Eau Claire, and on January 4 on KBJR-TV in Duluth, Minn, and on WFRV-TV in Green Bay. In Eau Claire, Don Griffith, MD, Eau Claire, participated in a panel discussion with health-care representatives, and in Duluth, Robert Seller, MD, president of the Douglas County Medical Society, participated in a similar panel. In Green Bay, Wallace MacMullen, MD, member of the SMS Commission on Public Information and Herbert Sandmire, MD, chairman of the Commission, were the first of several health-care providers interviewed on successive evenings on the WFRV-TV 6:00 pm and 10:00 pm news. ■

TENTATIVE SCHEDULE

Orthopedic Field Clinics

March 1978 through May 1978

STATE DEPARTMENT OF PUBLIC INSTRUCTION
DIVISION FOR HANDICAPPED CHILDREN

Bureau for Crippled Children

Location	*Date*	*Examiner*
Ashland	Late March	WT Brodhead, MD
Racine	Apr 12	MW Nelson, MD
Kenosha	Apr 13	AA Patel, MD
Chippewa Falls	Apr 27-28	AJ Ficke, MD
Lancaster	May 3 May 4	JD Heiden, MD JM Huffer, MD
Rhinelander	May 10	HI Okagaki, MD
Darlington	May 16	GH Vogt, MD

FOR: Clinics conducted by the Bureau for Crippled Children are for persons under 21 years of age for orthopedic diagnosis and consultation. Reports of the examinations are sent to the family physician following the clinic.

REFERRAL FORMS: May be obtained from the Bureau for Crippled Children and should be requested well in advance of the clinic date. Referral forms are made for each clinic so when requesting be sure to state how many are needed and for which clinic. It is important that we know in advance the number desiring clinic service so the caseload will not exceed clinic facilities. WE WOULD APPRECIATE HAVING ON THE REFERRAL FORM WHY THE CHILD IS BEING REFERRED TO CLINIC AND INCLUDE NAME, PARENTS' NAME, ADDRESS AND ZIP CODE.

CLINIC APPOINTMENTS: Families who return the referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

NOTE: We no longer require the signature of a physician on the referral form. We would appreciate, however, the name and address so we can send the report to him.

ADDRESS CORRESPONDENCE: Bureau for Crippled Children, 126 Langdon Street, Madison, Wisconsin 53702.

STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

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1903 · 1978 75th ANNIVERSARY YEAR

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LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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State Medical Society of Wisconsin

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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TITLE 19 PROVIDER CONTRACT COMING

The 1977-79 State Budget Bill mandated a contract for all providers who wish to participate in the Title 19 Medicaid program in Wisconsin. The contract will establish the terms of reimbursement that a provider will receive for services under the Medicaid program and is effective for one year from the date it is signed by the provider. Physicians can expect to receive the contract from the Department of Health and Social Services (DHSS) in late April or May 1978. The tentative date for physician-providers signing the contract is July 1, 1978; however, this may be changed by DHSS to a later date. *Physicians are reminded that this provider contract is required for reimbursement for Medicaid services; if a physician-provider does not sign the contract, he/she will not be reimbursed under the Medicaid program for those services rendered.* If physicians have a question concerning the contract, call the SMS Physicians Alliance office on the toll-free hotline: *1-800-362-9080.*

HEW ANNOUNCES POLICY ON SECOND OPINION SURGERY

The Department of Health, Education, and Welfare (DHEW) has announced a new policy of encouraging Medicare patients to seek second physician opinions when surgery is being considered. Thus, all Medicare carriers have now been instructed to pay Medicare claims for *patient initiated* second physician opinions that pertain to the medical need for surgery. In the event that the recommendations of the first and second physician differ, a patient-initiated third-physician opinion also will be reimbursable. Payments will be based on the reasonable charges carriers ordinarily allow for consultative and related services. *Physicians are asked to identify the second and third opinion services on the Medicare claim forms to facilitate payment for services.*

FRIVOLOUS LAWSUIT BILL RECEIVES APPROVAL

The State Senate and Assembly have passed Assembly Bill 237 which proposes to establish a general frivolous lawsuit statute in Wisconsin for all legal actions. A minor amendment was adopted by the Senate and the Assembly concurred. AB 237 allows any defendant in a lawsuit to move dismissal of the suit on grounds that the case is without any basis in law or equity, or that the suit is designed primarily to harass the defendant. This bill, which awaits Acting Governor Schreiber's signature, was strongly supported by the SMS Physicians Alliance because of its implications in medical malpractice cases.

ANNUAL MEETING PROGRAM SLATED ON COST CONTAINMENT

A Conference on "Cost Containment and the Physician" is planned for Thursday, April 13, at the SMS Annual Meeting. This conference is designed to inform and educate physicians on how they can influence public opinion concerning medical care costs, and how they can effect cost savings beneficial to their own practices (and thus their patients). The program is sponsored by the UW-Madison School of Medicine and the UW-Extension Health Sciences Unit/Department of Continuing Medical Education, in cooperation with the State Medical Society of Wisconsin and the Wisconsin Hospital Association. Registration fee is $18. For further details contact Barbara Wermuth at 608/263-2852; or make your check of $18 payable to COST CONTAINMENT PROGRAM, and mail to: UW-Extension, CME Coordinator, The Wisconsin Center, 702 Langdon Street, Madison, Wis 53706. ■

GUEST EDITORIAL

Defensive medicine

DUE TO THE LIABILITY climate in which we practice, many physicians consider it desirable to do more than is necessary in order to be able to defend themselves against unwarranted criticism. Since it has been reported several times that the best "defensive medicine" is good medical practice plus good rapport with the patient and the patient's family, laboratory and x-ray abuse can rarely be defended. Not only does it fail to achieve its goal but also it causes additional problems by escalating the cost of medical care.

One group of physicians seems especially vulnerable to complaint and especially likely to abuse the patient's pocketbook and insurer by unneeded studies. This is the emergency room physician who has little opportunity to develop a satisfying relationship with the patient's family. Too often the patient seemingly declares his condition to be an emergency when an additional day's wait to see his usual physician would be unlikely to cause harm, or the patient has already waited too long so that a minor condition has become serious. Too often the patient apparently has no concern about the economics of emergency room care—until he gets his next insurance premium notice. Efforts must be made—by emergency room physicians among others—to educate patients into the proper use of the emergency room and of physicians' offices.

Who benefits from the existent situation? Not the patient: he receives more expensive care of no higher quality. Not the physician: he loses the joy of helping a truely appreciative person with a minimum of cost and delay. Some hospitals do gain: added laboratory and x-ray studies mean additional revenue, which helps to offset decreased inpatient occupancy charges. Some hospital administrators, it seems, would like to have all medical care be hospital-based so that they can increase volume, control physicians, and continue growth of their institution when growth is no longer needed. Too many politicians and civil servants are watching all this happily—some from the sidelines and others in the headlines. They see increasing medical costs, disagreements between emergency room physicians and office-based physicians, controversy between hospital administrators and physicians—all of which are paving stones on their road to glory. No matter that in the long run they will suffer from this folly just as everyone else will.

What can we do about this? First, educate the patient where medical care can best be obtained at the lowest cost and highest quality—and establish our office routines with this in mind. Second, attempt to establish a good working relationship with every patient and his family. If this isn't possible with some patients or their families, maybe some other physician can more fully satisfy their needs. Third, have meetings with hospital administrators periodically to establish common goals. Remember, if we don't stand together we will surely fall separately. Maybe noting fees generated by the emergency room as emergency room income would help show how big a problem this has become. Fourth, meet and communicate with our legislators independently and through the State Medical Society's Physicians Alliance. Periodically they must be patients also; and if we can show them that the system works, they hopefully will be less eager to experiment with mediocrity.—MARTIN Z FRUCHTMAN, MD, Waukesha

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In Editoriols, the views expressed, if initioled or signed, ore those of the writer ond not necessorily officiol positions of the Society.

Fair game

RECENTLY THE Associated Press reported that a 20-year-old University of Wisconsin student had legislative approval to research the tax returns of hundreds of Wisconsin physicians. So far he has checked the net taxable income of about 2,000 physicians and has about 400 more to go to complete his study.

The State Department of Revenue freely admits that Wisconsin is acknowledged to have a tax record system that provides easier access to tax records than any other state. Apparently this was legislated originally to allow public officials to inspect tax files.

Correctly, Governor Schreiber and the Revenue Department have recommended that new limits on access be considered by legislators. At the present time there are about twenty legislative committees that have the power to authorize access to tax records. Their recommendation that this be confined to a single legislative committee certainly is a good one. Meanwhile, physicians and all other citizens are fair game!—VSF ■

LETTERS

Some Thoughts on WMJ

To the Editor: Soon after I started reading the *Wisconsin Medical Journal,* I recognized it as a medium for communication between all physicians in the State. This fact was brought home to me recently when I saw the President's Page in a 1930 number devoted to an explanation and defense of an increase of the annual dues to SMS to $10.00.

In this same number the Section on Preventive Medicine is devoted to the orthopedic treatment of some crippling conditions—polio, rickets, tuberculosis of bones, and congenital dislocation of hips.

Also, there are case reports on the use of insulin and the failure of its use by nasal instillation or by mouth.

Then, too, there are very complete case reports on some confusing conditions. These are given by prominent physicians in Madison, Milwaukee, and LaCrosse. These studies include all the diagnostic techniques available at that time, which by present standards are not what one might call sophisticated.

An article by one of the leading pediatricians on the use of boiled butter and flour in infant feeding was the newest import from Germany.

So what does all this add up to? Simply this: SMS and WMJ were involved in CME long before organized groups started the present day big push in that direction.

H Kent Tenney, MD
Madison, Wisconsin ■

WMJ's 75th anniversary

IN ITS 75th year of publication, the *Wisconsin Medical Journal* welcomes letters from its readers, recalling any events of historical or nostalgic significance that might be appropriate in the recognition of WMJ's 75th anniversary.

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SMS Annual Meeting: Seminars on Politics

THIS COLUMN HAS attempted over the last several months to shed some light on the political process at work in Wisconsin, especially as to how it affects the medical community.

It is always difficult to explain this system via the printed word; political science textbooks for years have made commendable attempts to so instruct the serious student of politics. However, anyone who has ever visited the Capitol in Madison and watched legislators, staff, and lobbyists at work, oftentimes comes away from that experience somewhat confused and awed.

This month, I will make no attempt to put political medicine in perspective. I will, however, strongly urge all of you who will be attending the State Medical Society Annual Meeting to consider attending one or all of the SMS Seminars on Politics to be conducted at the meeting.

These seminars will allow physicians to gather firsthand information about three important areas of political medicine: (1) health planning and what physicians can do about it; (2) political action programs—what they are and how physicians can participate; and (3) the 1977 Legislature—an overview and analysis.

The Health Planning Session will be held on **Friday, April 14** at **8:30 am** in **W-10/MECCA.**

The **Political Action Panel** will be held on **Saturday, April 15** at **8:30 am** in **W-10/MECCA.**

The **Legislative Review Session** will be held at **10:30 am** on **Saturday, April 15,** again in **W-10/MECCA.**

Physicians, staff, and legislators will be involved in these programs. I urge you to attend. I guarantee that future comments in this column will have more meaning to you *after* your participation in the sessions.

If you have questions, call the Alliance staff at SMS on the toll-free in-WATS hotline: 1-800-362-9080, ext. 115.

JOSEPH M LUBITZ, MD
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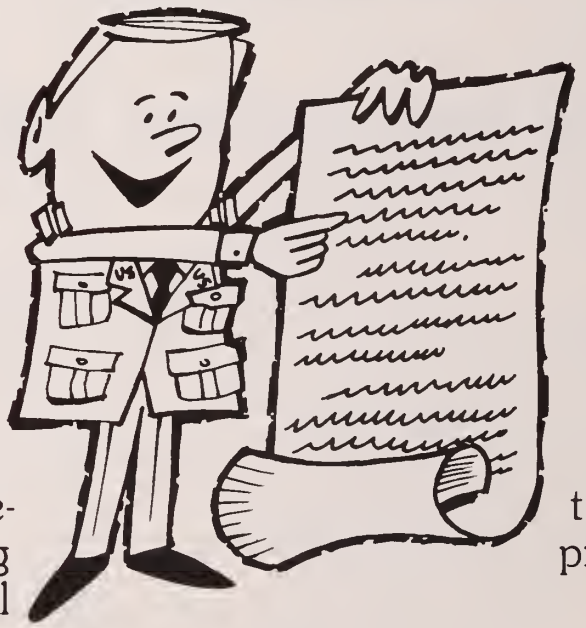

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Familiarity breeds contempt; unfamiliarity breeds misdiagnosis and poor treatment—OSLER

IN 1977 ABOUT 390,000 people died of cancer. However, the average pediatrician, surgeon, or general practitioner will probably only see malignant disease in children or pancreatic, esophageal, or other relatively uncommon adult cancers once or twice during his life. Even a medical center that serves an area with a million children will only see about 100 childhood malignancies a year. It is, therefore, very difficult for many physicians to diagnose and treat neoplastic diseases. Because physicians do not have the time to read in depth about uncommon cancers, they are often not aware of the current information about diagnosis and treatment necessary to adequately diagnose and treat malignancies and develop an appropriate management plan.

Diagnosis and treatment must be considered together. Frequently a patient's fate is determined by the initial therapeutic attempt; treatment errors cannot always be corrected. One physician cannot usually supply all the expertise necessary. The teamwork usually available at larger medical centers permits selection of the therapy best for a particular patient and administration in an aggressive, progressive manner. All members of the team—surgeons, radiologists, oncologists, pathologists, psychiatrists, social workers, nurses, technicians, and secretaries—must understand the disease, treatment, and possible complications to be realistic and sincerely optimistic towards the patient and the family. And they must work closely with the family physician to give continuity of care at home.

For example, teamwork has greatly improved the treatment of patients with Wilm's tumors. Surgery alone cured about 35 to 40 percent of the patients. Treatment of the tumor bed with radiotherapy after surgery increased the cure rate to about 47 percent. This was increased to 80 to 90 percent with chemotherapy.

According to Dr Paul P Carbone, Director of the Wisconsin Clinical Cancer Center in Madison, the clinical investigator who desires to use new methods of diagnosis and treatment for neoplasms which are rare or difficult to study must resort to collaborative and interinstitutional clinical trials.

In order to fill this need, two specialized networks have been established in Wisconsin. About three years ago a Head and Neck Cancer Network under the direction of Dr James H Brandenburg of the University of Wisconsin was established. Twelve institutions located in six Wisconsin cities joined together to share information and improve care of patients with head and neck cancer.

Responding to the urgent need to evaluate patients with abnormal cytology on a cervical Pap smear or negative cytology but grossly suspicious cervical lesions, the Wisconsin Colposcopy Network was established in 1974 under the direction of Dr Adolf Stafl of the Medical College of Wisconsin in Milwaukee. Now 12 centers belong to this network. Because of this cooperation, diagnostic accuracy has been improved and inflammatory atypia and cervical neoplasia differentiated. Fewer conizations are needed, so several million dollars in hospital expenses have been saved and there has been less patient morbidity.

The Midwest Children's Cancer Center of Milwaukee Children's Hospital and the Medical College of Wisconsin was also established in 1974, with Dr Donald Pinkel as director, to meet the needs of children and do research on childhood malignancies.

Also cooperative study groups have been established in which many large medical centers around the world work together to develop sound treatment plans. Patients with a certain type of neoplasia at specific stages of disease are placed in a study with similar patients from other centers. Treatment is planned so they receive the best known treatment available.

One such group, the Eastern Cooperative Oncology Group (ECOG) under the chairmanship of Doctor Carbone, now has its headquarters in Madison. This group of 39 institutions located in the United States, South Africa, France, Italy, and Australia cooperate together in studying the effectiveness of various cancer treatments and seeking answers to important basic questions concerning neoplastic growth. Through such cooperation, cancer patients benefit from the combined expertise of doctors around the world and help speed the accumulation of knowledge about cancer and its treatment.

Children's Hospital, which is part of University Hospitals in Madison, is a member of another cooperative group, the Children's Cancer Study Group A. According to Dr Dorothy Ganick, a pediatric hematologist-oncologist at the hospital, children are

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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kept at home as much as possible, but hospitalization is usually necessary for initial diagnosis and workup, the first few days of treatment, and radiotherapy. Close contact with the home-town doctor and health-care services gives the child continuity of care. Normally children come to Madison for checkups and outpatient treatment but are not hospitalized unless complications arise. Cooperation between the cooperative group, medical center, and home-town physician assures the child and family of the best possible care.

Because cancer patients are living longer, the medical staff must be concerned about rehabilitation of the patient to every day life and the physical and psychological aspects of a life-threatening disease. Since most children can return to school, clinical nurse specialists can work with families and teachers to help children adjust and prepare for a future that may include education, work, marriage, and even parenthood. Adult patients can be helped to adjust to changes in daily routine and to have a comfortable, satisfying personal life. Refinements in treatment are being studied; for example the high dosages of drugs and radiation presently given may be unnecessary for certain cancers. According to Doctor Ganick, even if the cancer cannot be cured, the disease can often be contained and pain controlled, so that the patient can be comfortable and participate in family, school, and community life as long as possible.

Doctor Carbone believes that interdisciplinary and interinstitutional research efforts should be continued, enlarged, and refined. Through cooperation, progress is being made in the treatment of acute lymphocytic leukemia in children, histiocytic lymphoma, Burkitt's lymphoma, retinoblastoma, Ewing's sarcoma, rhabdomyosarcoma, brain tumors, Wilm's tumors, osteogenic sarcomas, malignant melanoma, choriocarcinoma, Hodgkin's disease, and testicular carcinoma, as shown by decreases in recurrence, metastatic spread, and longer survival.

—Dorothy J Buchanan-Davidson, PhD,
Science Writer
Wisconsin Clinical Cancer Center

See the YELLOW PAGES . . .

For information about the Head and Neck Conferences to be held April 5, 6, and 20 in Racine, Beloit, and Sheboygan and the Spring Cancer Conference to be held in Fontana, May 18. ■

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Council releases statement on optometry bill

The SMS Council, in a rare move at its meeting February 4, issued a statement urging the Legislature not to enact 1977 Assembly Bill 281 which would allow optometrists to use drugs to diagnose ocular disease.

In its statement the Council said, "the enactment of this legislation would have no benefit to the general health and well-being of Wisconsin citizens, and in fact would pose a serious health hazard in the event of an adverse reaction to the drugs."

The Council joins the SMS Section on Ophthalmology and the SMS Commission on Governmental Affairs in publicly opposing the bill.

In other action February 4, the Council:

• Reviewed the proposed State Health Plan and authorized the SMS Commission on Health Facilities and Services to develop a position paper on the plan and present it at the public hearings to be held in March or April 1978. The position paper is to be based on comments from specialty societies, councilors, and any others to whom the plan has been sent for review.

• Recommended to the House of Delegates that SMS complete its separation from WPSIC. The Council also will send a statement to the House of Delegates outlining the pros and cons of this action, as well as other options.

• Formally thanked all SMS physicians, staff, lobbyists, and field consultants for their work on Senate Bill 108. SB 108, which mandated the inclusion of chiropractic coverage in all health insurance policies sold in Wisconsin, was vetoed by Acting Governor Martin Schreiber and the veto was sustained by the Legislature.

• Created a permanent Committee on Professional Liability as a subcommittee of the Physicians Alliance Commission (PAC), with its members to be appointed by the chairman of PAC.

• Appointed a 15-member ad hoc committee to develop a policy plan on private sector patient peer review in Wisconsin and to report back to the Council within 60 days. The Council strongly opposed the separate incorporation of WisPRO until the Council has received and acted upon the ad hoc committee's report. ■

GAC forms committee on lab certification

The SMS Commission on Governmental Affairs has appointed a special committee to develop a formal petition on amendments to Chapter H-38 of the Wisconsin Administrative Code which deals with the lab certification program of the Department of Health and Social Services (DHSS).

The 1977-79 state budget bill passed last June by the Legislature, requires that a lab certification fee of $250 be charged per specialty testing area. This represents a substantial increase for the private physician and hospital lab. All *state* facilities are exempt from the fee.

SMS plans to petition that the fee schedule be graduated per specialty testing area, as well as point out the ineffectiveness and duplicative nature of the state lab certification program in light of lab certification done by the College of American Pathologists.

The Governmental Affairs Commission appointed the following physicians to the special committee: Raymond Zastrow, MD, Wauwatosa; Jordon Frank, MD, Beloit; and Charles Nichols, MD, LaCrosse. ■

SMS testifies at 'super-rule' hearing

The State Medical Society presented a formal statement February 21 at a public hearing in Madison on what is commonly referred to as the "Medical Assistance Super-Rule."

This Super-Rule, as proposed by the Department of Health and Social Services (DHSS), is a revision of the Wisconsin Administrative Code, which will codify for the first time all Department policies regarding the Wisconsin Medical Assistance Program. At the hearing the Society raised several objections to sections of the rule which would pose serious problems for physicians. Among those areas addressed are:

• MEDICAL RECORDS, Section 5.02 (3)—Requires physicians to keep numerous records including but not limited to Title 19 (Medicaid) billings. In particular, it requires the physicians to maintain "record of services to patients."

"The DHSS has no authority to require provider physicians to maintain records for non-Title 19 patients . . . While we do feel that the Department has some authority to require participating physicians to maintain records relative to the Title 19 program, we do not feel that that authority extends to the records maintained for 'private paying' patients."

• REDUCTION IN REIMBURSEMENT RATES, Section 6.06 (7), (8) and (9) —Gives DHSS the authority to reduce payments to physicians by up to ten percent if the Department anticipates exceeding its Title 19 budget.

"This would vest in the Department very broad, if not complete discretion to reduce reimbursement levels to physician-providers which is contrary to the provisions of the provider's contract. The effects of this proposed rule would be the equivalent of the freeze which has been declared illegal and contrary to the Department's statutory duty to make periodic rate determinations. It is discriminatory against physician-providers. The Society strongly objects to this provision and insists upon its deletion."

• PROVIDER RIGHTS, Section 6.02 (3)—If the Department determines that there has been an overpayment to a Title 19 provider, the Department may escrow that amount out of future payments to that provider.

"This rule does not adequately provide for the application of the fair play provisions and protections of Chapter 227 of the Wisconsin Statutes. There should be language within the rule itself which makes an expressed provision that any decision of the Department to make a deduction from future Medicaid payments, and a physician's objections thereto, should be subject to the procedures provided for by the 'contested case' provisions of Chapter 227, Wisconsin Statutes, and in particular, the statutory require-

ments for the conduct of a 'Class 2' proceeding."

• PROVIDER SANCTIONS, Section 6.02 (4)—Provides that a physician-provider is not subject to civil or criminal sanctions when releasing records or information regarding Medical Assistance recipients, if such release is for the purposes directly related to the administration of the program.

"While legislation is currently pending in the form of the Budget Review Bill to amend various sections of the Wisconsin Statutes relative to the physician-patient privilege, the proposed rule is objectionable because the general statute has not been amended at this time. The Department is without authority to grant such a waiver relative to the release of medical records."

"In conclusion, the State Medical Society feels that the public record on this hearing must be kept open for at least 30-45 days following the conclusion of the hearings in order that we might submit additional comments."

Copies of the SMS statement are available to any SMS member. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.25 as of Nov 30, 1977 and $2.72 as of Dec 30, 1977. ■

COUNTY SOCIETIES

RACINE

Dennis J Kontra, MD, Racine, is the new president of the Racine County Medical Society. Other MDs elected to office are: James R Hammes, president-elect; Huron L Ericson, secretary; and Victoriano A Baylon, treasurer, all of Racine.

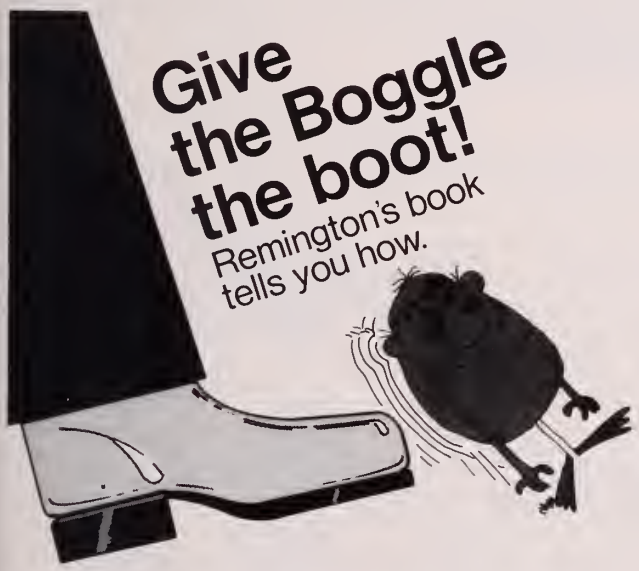
MILWAUKEE

The Milwaukee County Medical Society Board of Directors has adopted recommendations of its Long Range Planning Committee to seek a grant and study feasibility of establishing a Health Education Center in Milwaukee to stimulate greater public awareness and knowledge about general health matters. The Center could serve as a valuable resource to physicians by supplementing their own patient education efforts, the Board noted.

The Society's Emergency Medical Services Committee has received Board authorization to spearhead a study of perceived problems in hospital emergency department care. A joint study committee is being established in cooperation with the local Hospital Council. Roadblocks to effective and efficient hospital emergency care will be identified and solutions formulated to assist hospitals and medical staffs which provide emergency department service, the Society's newsletter stated.

New officers for 1978 are: Shimpei Sakaguchi, MD, president; Derward Lepley Jr, MD, president-elect; and Joseph Teresi, MD, secretary-treasurer.

Joseph Darin, MD, immediate past president, was elected to a three-year



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term as a director-at-large, and James O'Connell, MD was elected to another three-year term as a director. Completing a term on the Board was Donald Babbitt, MD. Sidney Wynn, MD, a retiring Board member, completed a term as secretary-treasurer. Other members of the Board are: MDs Chesley Erwin, Marvin Glicklich, Archebald Pequet, and Marvin Wagner.

SAUK

Representatives Tommy Thompson and Pete Litscher, and Senator Everett Bidwell were guests of the Sauk County Medical Society in January. They discussed their perceptions of upcoming legislation of medically related bills and other important issues of importance to the people of Wisconsin.

Medical society feedback to the legislators was an important issue of the meeting. It was noted that communication channels had been opened up. Legislators expressed their ongoing need for frequent and recurrent contacts with physicians and expressed their desire for contact on the part of individual physicians.

Representative Tommy Thompson, Homer Baker, MD, and Otto Pawlisch, MD during a break in their discussion of upcoming medical legislation in Wisconsin.

WOOD

The first meeting in 1978 for the Wood County Medical Society was held in January with Jung K Park, MD, Wisconsin Rapids, president, presiding. Doctor Park announced his goal for the year as being one of Society promotion of communication and friendship.

Committees were appointed for 1978 as follows:

Program and Scientific Work—MDs JL Hoehn (chairman), JE Thompson, and RA Dart.

Comprehensive Medical Health—MDs GE Porter and RL Johnson (co-chairmen), RF Lewis, MT Wood, NW Arendt, CH Starr, LR Pfeiffer, and CE Sampson.

Public Policy and Information—MDs RF Lewis (chairman), BR Lawton, CC Sorensen, RH Ulmer, LR Pfeiffer, JW McDonough, PS Treuhaft, and GE Porter.

Public Health and Welfare—MDs JW Schaller (chairman), AW Hulme, JC Opitz, JL Ousley, EW Walters, JD Lee, RJ Rowe, and Tim Huebner.

Civil Defense and Disaster—MDs EG Mills (chairman), JA Wilson,

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Special Committee to Rewrite By-laws in 1978—MDs HH Russ (chairman), JK Park, GE Porter, and RL Johnson.

Occupational Medicine—MDs WJ Boulet (chairman), CH Starr, and WV Dovenbarger.

The scientific portion of the meeting was cosponsored by the Marshfield Clinic and was given by Dieter M Voss, MD, cardiologist, whose talk was entitled, "Cardiac Rehabilitation in Europe and America." Doctor Voss drew from experience he had gained on his sabbatical spent in West Germany. His talk was illustrated with many slides depicting scenery, hospitals, and rehabilitation clinics. A summary of his talk appears in the SCIENTIFIC MEDICINE section of this issue.

The Marshfield Clinic certified one hour of AMA Category I credit for those physicians who attended the meeting. ■

1978 SMS

ANNUAL MEETING

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THIS ISSUE ON

PAGES 43-47

DIVISION OF HEALTH/physician alert

Death associated with gas from liquid manure system

County and state health officials have documented that a December 8, 1977, death of a 16-year-old farm worker was due to exposure to hydrogen sulfide (H_2S) gas.

The source of H_2S was traced to decomposing liquid manure that was being agitated in a 100,000-gallon tank located under a kosher calf barn. The victim was cleaning barn gutters inside the barn approximately 30 feet from the tank when he was overcome by fumes and collapsed with death occurring shortly thereafter. Two other workers experienced syncopal episodes during attempts to rescue the victim.

Deaths also have occurred when individuals have entered liquid manure system tanks.

Although steps are being taken to educate farmers about this problem, physicians should be aware of this potential health hazard among farm workers. Exposure to low concentrations of H_2S can cause headache, mucous membrane and respiratory tract irritation, nausea, and dizziness. This usually occurs in association with a rotten egg odor. However, sense of smell does not provide a reliable warning because of rapid extinction of olfactory sensation with increasing concentrations. Syncope and death secondary to respiratory paralysis can occur at high concentrations with little or no warning.

The potential magnitude of the problem is becoming more widely recognized as the number of liquid manure systems increases.

Physicians seeing farm workers with symptoms compatible with H_2S exposure should warn the farm worker to evacuate all humans and animals when agitating a liquid manure tank that is located inside or under a barn. Workers and animals should remain out of the building for a period of time after agitation. The Agriculture Extension will provide assistance in evaluating the adequacy of the ventilation system in use with liquid manure tanks constructed inside of a building.

Physicians, if you know of any documented human or animal illnesses or deaths associated with liquid manure fumes, please call the Wisconsin Division of Health collect at 608/266-1251 or write to the Bureau of Prevention, PO Box 309, Madison, Wis 53701.

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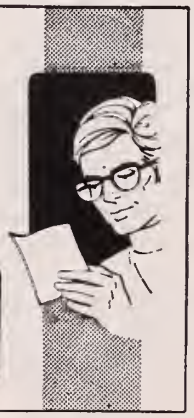

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of January 20, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

ASHFIELD-BAYFIELD-IRON

Peterson, John O H, 2101 Beaser Ave, Ashland 54806 (1932, Regular, Radiology, Certified)

GREEN LAKE-WAUSHARA

Emlano, Pepito M, PO Box 265, Wild Rose 54984 (1939, Regular, General Practice)

MILWAUKEE

Chojnacki, Michael J, 1220 Dewey Ave, Milwaukee 53226 (1944, Regular, Psychiatry)
Dhamee, Mohammed S, 8700 W Wisconsin Ave, Milwaukee 53226 (1936, Regular, Anesthesiology)
Forman, Sheldon R, 707 W Glencoe Place, Milwaukee 53217 (1942, Regular, Internal Medicine/Anesthesiology, Certified-IM)
Gandhi, Shanilal K, 8700 W Wisconsin Ave, Milwaukee 53226 (1935, Regular, Anesthesiology)
Hanson, Gerald A, 8700 W Wisconsin Ave, Milwaukee 53226 (1943, Regular, Pathology, Certified)
Millan, Alfredo C, 606 W Wisconsin Ave, Milwaukee 53203 (1937, Regular, Obstetrics and Gynecology)
Munkwitz, George A, 425 E Wisconsin Ave, Milwaukee 53203 (1948, Regular, Internal Medicine, Certified)

PIERCE-ST CROIX

Scheibel, William R, 158 N Greaton Rd, New Richmond 54017 (1948, Regular, Family Physician)

PRICE-TAYLOR

Borish, Jane, 500 Birch St, Park Falls 54552 (1949, Regular, Internal Medicine/Pathology)

WAUKESHA

Bolan, Robert K, 123 Lawn St, Hartland 53029 (1946, Regular, Family Physician)
Hausmann, Paul F, 217 Wisconsin Ave, Waukesha 53186 (1913, Regular, Thoracic Surgery/General Surgery, Certified-GS)
Switala, Jean M, 15211 W Vera Cruz Dr, New Berlin 53151 (1950, Resident, Internal Medicine)

WOOD

Gibson, Mark S, 1120 Onstad, Marshfield 54449 (1946, Regular, Emergency Medicine/Internal Medicine)
Molina, J Ernesto, 1000 N Oak Ave, Marshfield 54449 (1935, Regular, Cardiovascular Surgery/Thoracic Surgery, Certified-TS)
Pagels, George A, 1000 N Oak Ave, Marshfield 54449 (1947), Regular, Internal Medicine, Certified)
Wolski, Kenneth P, 1000 N Oak Ave, Marshfield 54449 (1942, Regular, Rheumatology/Internal Medicine)

DEATHS

Schwei, George P, Winnebago County, Jan 8, 1978
Bennett, William H, Racine County, Jan 19, 1978

Membership Report as of February 21, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BROWN

Bressler, Bruce C, 704 S Webster Ave, Green Bay 54301 (1942, Regular, Neurological Surgery)
Foster, W James, 417 S Monroe Ave, Green Bay 54301 (1943, Regular, Ophthalmology)
Lacey, James V, 1821 S Webster Ave, Green Bay 54301 (1944, Regular, Internal Medicine/Hematology, Certified-IM)
Nelson, William L Jr, 900 S Webster Ave, Green Bay 54301 (1946, Regular, Internal Medicine/Family Physician, Certified-IM)

DANE

Bartlett, David H, 2704 Marshall Court, Madison 53705 (1947, Regular, Orthopedic Surgery)
Paster, Robert M, 726 N Main St, Oregon 53575 (1947, Regular, Family Physician/Emergency Medicine)

FOND DU LAC

Chen, John J W, 525 E Division St, Fond du Lac 54935 (1946, Regular, Family Physician)

GREEN

Nair, Bharathy V, 1515 10th St, Monroe 53566 (1947, Regular, General Practice)

MILWAUKEE

Gorsky, Budd A, 3485 North Murray Ave, Milwaukee 53211 (1946, Regular, Family Physician)

PORTAGE

Katz, Paul G, 2501 Main St, Stevens Point 54481 (1947, Regular, Urology)

ROCK

La Breche, Michael J, P O Box 351, Janesville 53545 (1931, Regular, General Practice)
Onderak, Edward P, 1969 W Hart Rd, Beloit 53511 (1927, Regular, Radiology, Certified)

SHEBOYGAN

Kalchthaler, Thomas (DO), 1902 Mead Ave, Sheboygan 53081 (1943, Regular, Internal Medicine/Geriatrics, Certified-IM)

WAUKESHA

Beranek, Pamela M, N87 W17959 Shepherd Dr, Menomonee Falls 53051 (1948, Regular, Family Physician)
Dougherty, Thomas J, 1111 Delafield St, Waukesha 53186 (1942, Regular, Internal Medicine, Certified)
Iverson, Gary O, W180 N7950 Townhall Rd, Menomonee Falls 53051 (1948, Regular, Internal Medicine, Certified)

WINNEBAGO

Burns, James R, 508 Quarry Lane, Neenah 54956 (1948, Regular, Internal Medicine, Certified)
Ilvedson, Ronald E, 712 Doctors Court, Oshkosh 54901 (1936, Regular, Obstetrics and Gynecology)
Turner, Donald C, 1209 S Commercial, Neenah 54956 (1941, Regular, Radiology, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BARRON-WASHBURN-BURNETT

Cornforth, Donald E, Shell Lake, to 336 Gerland Rd, Rice Lake 54868

DANE

Goodman, George B, Madison, to 1603 Locust St, Marshfield 54449
Hert, Robert C Jr, Madison, to 600 McClurg Court, Chicago, IL 60611
Junck, Marlen F, Madison, to 265 Greenwood, Holland, MI 49423
Van Riper, Hart E, New York, to 500 South East 21st Ave, Deerfield Beach, FL 33441
Wolfson, Justin J, Madison, to 6521 Medical Center, Shreveport, LA 74102

EAU CLAIRE-DUNN-PEPIN

Cameron, William G, North Fort Myers, FL, to 2616 Irene Drive, Eau Claire 54701

MILWAUKEE

Frackelton, W H, Milwaukee, to 15 Victoria Dr, Moss Creek Plantation, Hilton Head Island, SC 29928
Riddle, Patrick J, Gainesville, FL, to 111 Saint James Gretna, LA 70053
Saltzstein, Edward C, Milwaukee, to 4800 Alberta St, El Paso, TX 79905

PIERCE-ST CROIX

Gwin, John F, Hudson, to 4018 North 116th Circle, Omaha, NE 54016

WINNEBAGO

Payne, James C, Oshkosh, to Star Route, Dubois, WY 82513

DEATHS

Huston, John, Milwaukee County, Jan 18, 1978
Quick, Armand J, Milwaukee County, Jan 26, 1978
Winnik, Donald E, Milwaukee County, Jan 26, 1978
Beatty, Samuel R, Winnebago County, Jan 29, 1978
Pfeiffer, Oliver W, Racine County, Feb 1, 1978
Ross, Fordyce A, Milwaukee County, Feb 2, 1978
Heller, Theodore A, Milwaukee County, Feb 7, 1978 ■

OBITUARIES

◈County, State, AMA Members

◈ **Frederick C Heidner, MD,** 77, Milwaukee, died Dec 17, 1977 in Milwaukee. Born Sept 20, 1900 in West Bend, Doctor Heidner graduated from Rush Medical College, Chicago, in 1924. He served as chief-of-staff at Deaconess Hospital, Milwaukee, and was a member of the hospital staff of Columbia Hospital. For several years he served as medical advisor to the board of the Curative Workshop. Surviving are his widow, Esther; and two sons, Frederick, Santa Barbara, Calif, and John of Milwaukee.

◈ **George P Schwei, MD,** 66, Neenah, died Jan 8, 1978 in Neenah. Born May 28, 1911 in Milwaukee, Doctor Schwei graduated from Marquette University School of Medicine in 1942. Doctor Schwei was associated with the Jackson Clinic, Madison, prior to moving to Neenah in 1951. He practiced in Neenah at the Riverside clinic until 1973 when he became associated with Theda Clark Hospital Emergency Department. He served in the United States Navy during World War II from 1944-1946. Surviving are his widow, Carol; a daughter, Barbara, New York; and four sons, Matthew, Joseph, David, all at home; and Peter of Madison.

◈ **William Harold Bennett, MD,** 75, Racine, died Jan 19, 1978 in Racine. Born May 15, 1902 in Fort Atkinson, Doctor Bennett graduated from the University of Illinois Medical College in 1927 and practiced general medicine in Kenosha from 1928-1940. From 1941-1943, he served a residency in ophthalmology at Tulane University, New Orleans, La, and practiced ophthalmology in Racine until his retirement in 1977. He also served in the United States Navy from 1943-1946. He is a past president of the Kenosha County Medical Society and the Racine County Medical Society. Doctor Bennett also was active in medical missionary work serving in Taiwan, Guatemala and Haiti. Surviving are his widow, Martha; three sons, Peter and John of Racine, and David, Nashville, Tenn; and a daughter, Joan Samson of New Orleans.

◈ **Chester A DeWitt, MD,** 76, Silver Lake, died Jan 26, 1978 in Silver Lake. Born Mar 24, 1901 in Spring Lake, Mich, Doctor DeWitt graduated from the University of Michigan Medical School in 1925. He practiced medicine in Racine and Kalamazoo, Mich before moving to Silver Lake in 1936. Doctor DeWitt was in active practice until the time of his death. Surviving are his widow, Doris; two stepdaughters, Mrs Katherine Elverman, Salem, and Mrs Ruth Gerber, Silver Lake; and one stepson, Eugene Miller of Silver Lake. His first wife died in 1971.

◈ **Samuel Richard Beatty, MD,** 74, Cocoa Beach, Fla, died Jan 29, 1978 in Cocoa Beach, Fla. Born Aug 1, 1903 in Beverly, Ohio, Doctor Beatty graduated from the University of Wisconsin Medical School in 1932. He was a former president of the Wisconsin Radiological Society and the Winnebago County Medical Society. Doctor Beatty, who practiced radiology at Theda Clark Regional Medical Center, Mercy Medical Center, and Winnebago Mental Health Institute, retired in 1973. Surviving are his widow, Meredyth; three daughters, Mrs Edward (Janice) Lawrence, Ypsilanti, Mich; Mrs James (Margaret) Burns, Jackson, Tenn; and Mrs Joseph (Barbara) Baughman, Winnetka, Ill. ■

"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 a.m. and 4:30 p.m. weekdays. The number to dial is:

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Keep this number handy for easy reference! The SMS staff welcomes this additional service in making it more accessible to members.

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

December 10, 1977—Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 9:10 am on Saturday, December 10, 1977, at the State Medical Society.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Doctors Boulanger, Schmidt, Foley, Bruhn, Mullooly, Eisenberg, Crowley, Tuftee, Waterhouse, Natoli, Kief, Lewis, Peters, Flaherty, Smejkal, Barrette, Doyle, Picard, Larsen, Levin, Motzel, Taebel.

Others present (part or entire): Doctors Nordby, Derus, Twelmeyer, Collentine, Williams, Scott, Biek; Mrs Lyons; Messrs Thayer, Simms, Johnson, Wendle, Brown, McIntyre, Jensen, Nelson, Brower, LaBissoniere; Horton and Martin, consultants; Mmes Bartel, Price-Marcus, Upton, Angell, Reinhardt; Miss Pyre.

2. Approval of Minutes of October 15, 1977

Minutes of the last meeting were approved on motion of Doctors Picard-Mullooly, carried.

3. Report of Executive Committee

Doctor Larsen reported discussions and interim actions of the Executive Committee on November 11 relative to national health planning guidelines, the Medical Examining Board administrative rule on amphetamines, 1978 annual meeting events, and appointment of an unnecessary surgery study committee.

On motion of Doctor Larsen, seconded and carried, the Council approved the following report and action concerning WMJ advertising policy:

An advertisement announcing the opening of an office in Milwaukee by two podiatrists had been submitted for insertion in the *Wisconsin Medical Journal*. After discussion, the committee determined that advertising by limited licensees not be accepted by WMJ unless such advertisement includes identification of the supervising physician or physicians.

4. E Paul Barnhart, consulting actuary

Mr Barnhart was retained by the Council for actuarial work in connection with WPS as a division of the Society. He has had indication that WPSIC will continue to use his services and proposed that the Society terminate the consultant relationship if it no longer required his services so he would be "freer" to consult directly with WPS.

On motion of Doctors Natoli-Waterhouse, carried, the Council terminated retention of E Paul Barnhart as consulting actuary.

5. Report of Physicians Alliance Commission

The Council accepted the following recommendations from the Physicians Alliance Commission relative to adoption of a uniform claim form and billing procedures:

A. Accept the AMA uniform claim form as the standard health insurance claim form for use by physicians' offices in Wisconsin with all third-party carriers including government programs.

B. Adopt the CPT-4 procedure (service) code for reporting of services to all third parties beginning January 1, 1978, and with full implementation no later than July 1, 1978.

C. Adopt the HICDA diagnosis code for the reporting of services to all third parties beginning January 1, 1978, with full implementation no later than July 1, 1978.

D. Work with EDS (and other carriers where possible) to develop a uniform coding for supplies and equipment used in physicians' offices. This will be accomplished through a joint PAC and clinic manager committee working with EDS.

E. Form an advisory committee to work with DHSS to evaluate proposed new procedural changes or rules.

The Commission reported further that it plans to undertake a thorough analysis of Wisconsin physician Medicare profiles; how they are constituted and what can be done to remedy incorrect profiles; and to study the possibility of developing a single profile region for Wisconsin.

Mr Simms reported that it appeared certain the State would shortly offer an 80% advance on outstanding pre-July 1 Medicaid claims; also that negotiations were under way relative to obstetric and pediatric claim problems.

6. Patient Rights and Responsibilities

A statement on patient rights and responsibilities was approved by the Council some time ago for distribution on a voluntary basis through physician offices and hospitals. Such distribution has not been accomplished by DHSS despite pleas from the Society. Meanwhile, several legislators are pressing for a bill of rights and responsibilities, and a committee of the Commission on Governmental Affairs has been assigned to the subject in the belief that the Society cannot simply oppose or refuse to discuss possible legislation. It had been intended

Continued on page 36

NEWS YOU CAN USE

WATS LINE READY FOR MEMBERS

Don't forget about the In-WATS line! SMS members can now contact anyone at SMS headquarters in Madison from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. THE NUMBER TO DIAL IS: 1-800-362-9080.

SURVEY SHOWS "CRISIS" IN HEALTH CARE

A recent study by the University of Chicago shows that 61 percent of Americans think there is a crisis in health care—at least for other people. However, only 12 percent say they are generally dissatisfied with the health care they themselves receive. The causes of dissatisfaction most frequently cited were high costs and long amounts of time spent in waiting rooms. ■

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'Ancef' is present in bone, synovial fluid, skin and soft tissues (such as pleural fluid and lymph nodes).

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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to discuss the matter with the Commission on Public Information, which was involved in development of the statement, but its meeting was cancelled because of bad weather.

It was suggested that in the event the issue came to a head before the next Council meeting, the chairmen of the Commissions on Governmental Affairs and Public Information jointly with staff be authorized to work with legislators and continue to express the preference for distribution of a voluntary statement, or at least seek to assure that no legislation is introduced or passed which is felt to be detrimental to the interests of patients or physicians.

On motion of Doctors Picard-Mullooly, carried, such authority was granted by the Council.

7. Report of AMA Delegation

Doctor Twelmeyer reported that the Wisconsin resolutions relating to a Federation membership campaign and dues reduction are to be the subject of a study and report at the 1978 Annual Convention. The delegation with support of the Council would like to nominate Doctor Collentine for appointment to the AMA Council on Long Range Planning. In reference to the report of the National Commission on the Cost of Medical Care, the delegation would be interested in any suggestions from the Council as to resolutions for introduction to the AMA House of Delegates.

On motion of Doctors Mullooly-Smejkal, carried, the report was accepted by the Council.

8. Private Sector Review Proposal from WHCRI

Doctor Waterhouse reviewed the considerations involved in the Council's October action supporting in principle the concept of the private sector conducting quality assurance peer review on a statewide basis and requesting that the details of the program by which WHCRI is to accomplish this be developed by WHCRI and returned to the Council for review. He indicated that the proposal circulated to the Council by a WHCRI steering committee chaired by William Rock, MD, was a preliminary report in terms of mechanics of the private review process for Council review and comment. He also presented names of the types of physicians recommended for Council or Executive Committee appointment to Medical Quality of Care Committee to provide leadership for this program.

After discussion, on motion of Doctors Eisenberg-Flaherty, carried, the proposal was tabled until the next Council meeting to allow time for appropriate interfacing of interested organizations.

Following luncheon recess, Doctors Waterhouse-Larsen moved reconsideration of the tabling motion; carried.

On motion of Doctors Waterhouse-Levin, carried, the Council requested that the Executive Committee appoint a committee representing the various organizations involved in physician peer review (FMCE, WisPRO, WHCRI) and under the leadership of the State Medical Society bring them together to work out their relationships to a private peer review effort and report back to the Council at its next meeting on February 4. The individuals named earlier were suggested as the initial group to constitute such committee. In response to questions, it was understood that this committee might be expected to recommend modifications in the WHCRI proposal.

9. Annual Meeting Registration Fee for Nonmembers

The Wisconsin Surgical Society had objected to the $25 registration fee for members of that Society attending the annual meeting who are not members of SMS. The Commission on Continuing Medical Education reaffirmed its position on the registration fee which is waived for all SMS members and members of other state associations, and referred the question to the Council which had previously approved the $25 fee, a reduction from $100.

On motion of Doctors Natoli-Picard, carried, the Council supported the Commission on Continuing Medical Education position on the registration fee.

[The Council then recessed to meet as corporate members of WPSIC, followed by lunch.]

10. SMS Goals, Objectives and Projects

In continuation of the Council's planning seminar held in Wausau in September, Mr. Thomas Martin suggested, in summary, that the next step was to prioritize the identified objectives and projects taking into account the availability and capability of both staff and the volunteer sector as well as budget.

Mr Thayer discussed a paper prepared by staff since the Wausau meeting which attempted to identify *all* of the goals,

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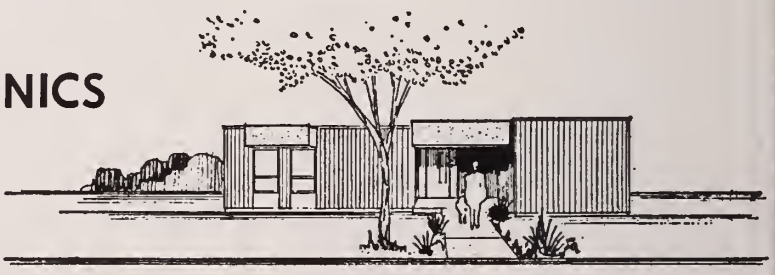

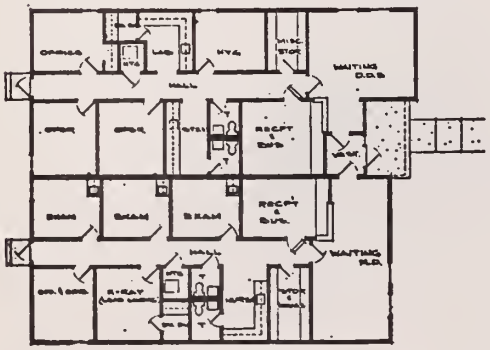

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objectives and projects of the Society assigned to the various commissions and committees, including the 21 projects listed in Mr Martin's report on the planning seminar. Taken in total, the projects were felt to fall into five major areas: (1) increasing and strengthening membership through communications and improved relationships with specialty societies; (2) maintaining and expanding legislative-political gains; (3) health planning; (4) strengthening quality care and peer review activities including discipline; and (5) new membership services and income alternatives.

He then reviewed the present status of the 21 objectives or projects identified at Wausau, resulting in Council actions as follows:

On motion of Doctors Flaherty-Levin, carried, the Council approved installation of a limited in-WATS line for use by the membership on a year's trial basis.

On the subject of relations with specialty affiliates, Doctor Levin reported the December action of the AMA House of Delegates whereby representation in that body will henceforth be through specialty societies rather than sections, providing the national specialty societies have 1,000 or more AMA members or, if fewer, represent a specialty that has an approved examining board listed in the *Directory of Accredited Residencies.*

There was discussion of a Council resolution to the House of Delegates recommending like action at the state level. A motion to this effect was withdrawn pending review of present specialty representation and what kind of numbers would be represented through specialty societies rather than sections.

In discussion concerning establishment of relationships with counterpart groups, and specifically with reference to independent nurse practice developments, Mr Thayer indicated the need for preparation of some guidelines as a policy matter.

On motion of Doctor Lewis, seconded and carried, the Council requested preparation of a position paper on this for the next meeting.

In reference to review and development of medical cost data, Doctor Larsen reported the following recommendations of the Committee on Evaluation of Delivery and Cost of Medical Care that:

A. the committee be immediately assigned the task of reviewing the recommendations of the National Commission on the Cost of Medical Care and prepare such recommendations as it sees fit for further action by the Council;

B. the committee be directed to meet promptly to consider the implementation of the House of Delegates report calling for joint state medical-hospital voluntary cost-containment efforts;

C. that the Council empower the committee to undertake such joint activities if in its best judgment it would be appropriate to do so prior to the next meeting of the Council;

D. the committee to prepare a full report for the Council at its next meeting.

On motion of Doctors Larsen-Picard, carried, these recommendations were approved by the Council.

It was generally agreed that the document prepared by staff be accepted as a working statement of goals, objectives and projects of the Society to be monitored for the time being by the Executive Committee which in turn would request reports from responsible commissions and committees so that it can be modified and refined on a continuing basis. The suggestion was made that the Executive Committee consider the possibility of establishing a long range planning committee as the "watchdog" group.

11. Termination of Ad Hoc Committee on Chiropractic

DeLore Williams, MD, reported his recommendation, concurred in by a poll of the members, that this committee be dissolved and its function transferred to the Commission on Governmental Affairs which meets on a regular basis.

On motion of Doctors Levin-Picard, carried, the recommendation was approved by the Council with thanks to the committee for its work.

12. Report of Finance Committee

Doctor Edwards reported on the deliberations of the committee in arriving at the proposed 1978 operating and capital budgets recommended for Council approval. He noted the

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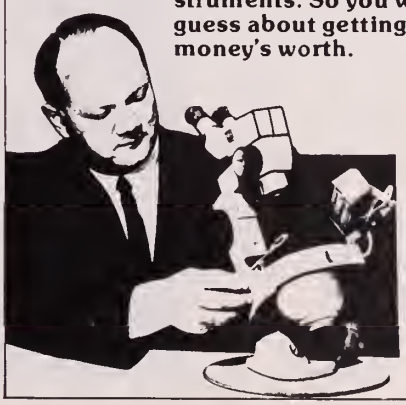

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intent of the Finance Committee that the level of expenses authorized for each specific area be that proposed by the budget. Should problems arise that require additional expenditures not intended in the budget as presented, the committee will review them and make recommendations to the Council. If adjustments are approved, the costs will be applied against the contingency line item and not against a departmental budget. It was felt that by so doing the committee and Council will retain a closer control on finances of the Society.

On motion of Doctors Edwards-Mullooly, carried, the budget was approved as presented.

On motion of Doctors Edwards-Levin, carried, any balance in the fund reserved to the Ad Hoc Committee on Chiropractic was transferred to the general fund.

Two salary increases were reported and approved by the Council in a brief executive session prior to adjournment.

13. SMS-WPSIC Relationships

The Council at its October meeting had requested that the matter of options concerning SMS-WPSIC relationships be placed on the December agenda for discussion and possible disposition. In view of the morning session of the Council as the corporate membership of WPSIC at which a majority of members of the WPSIC board of directors was present, discussion of the options was not considered at this time.

14. Miscellaneous

A. The Council approved the nomination of Roy B Larsen, MD, as a nonlawyer member of the State Bar Board of Governors.

B. Doctor NN

Mr Thayer reported the recommendation of the Commission on Peer Review that the Council return this matter (reported by Doctor Kempthorne at the October meeting on behalf of the Commission on Mediation and Professional Ethics) to the Commission on Peer Review so that it may assume the responsibility for an audit of Doctor NN's practice.

Doctors Edwards-Levin moved approval of the recommendation.

Doctor Barrette, Council Liaison to the Commission on Mediation and Professional Ethics, stated that this commission felt it was to carry through in monitoring the physician's practice, and urged that its chairman be consulted concerning the proposed action; further that more than one physician should be involved in the review, including at least one primary care physician from a practice setting comparable to that of Doctor NN.

Doctors Kief and Edwards indicated that the Commission on Peer Review intended that the review extend beyond the one physician, and be conducted by more than one member, including a primary care practitioner.

The motion carried with a statement by the Council chairman that if possible a member from each commission be utilized in the review of this situation.

15. Adjournment

The Council adjourned at 4:20 pm.

EARL R. THAYER
Secretary

Approved February 4, 1978
PAUL S. HASKINS, MD
Chairman

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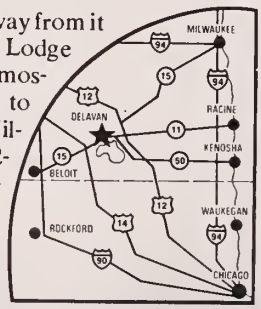

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Annual Meeting: 41 resolutions set issues

The House of Delegates will consider resolutions ranging in subject matter from unified membership to the AMA presidency at the State Medical Society's Annual Meeting in Milwaukee April 13-15.

The following resolutions were received in the Secretary's office by the February 13 deadline. These will go to the House of Delegates for action during its three sessions at the MECCA in Milwaukee. Members are urged to express their opinions to their delegates and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

A TIMETABLE of the Annual Meeting Program as well as a list of the delegates and alternates appear elsewhere in this issue.

(The county medical society, individual physician, or specialty section which introduced the resolution appears in parentheses.)

1. (Lincoln) Unified Membership

Because the question of unified membership of the SMS and AMA has been presented to the House many times, with innumerable man-hours spent in discussion, this resolution calls for action to resolve the issue once and for all: "that the House of Delegates . . . conduct a referendum via the mail of all members of the State Medical Society on the following questions, the results of such a referendum being interpreted as being binding on the House of Delegates . . .

"(1) Should membership in the American Medical Association be on a voluntary basis in Wisconsin?

"(2) Should the House of Delegates . . . amend the Constitution of the State Medical Society of Wisconsin to allow such voluntary membership?

"(3) Should the results of such a referendum be binding on the House of Delegates?

"(4) Should Article IV of the Constitution of the State Medical Society be amended to delete the words 'and, who shall also be members in good standing of the American Medical Association,' so that Article IV would then read: 'This Society shall consist of members who shall be the members of the component county medical societies, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.'? "

2. (Lincoln) Unified Membership

"RESOLVED, that if the results of the referendum demonstrate that more than three-fourths of the members of the State Medical Society of Wisconsin desire membership in The American Medical Association to be on a voluntary basis that Article XIII of the Constitution be changed so that the desires of the members of the State Medical Society of Wisconsin be instituted immediately. In effect. this would be interpreted that the membership of the State Medical Society of Wisconsin would feel that a three-fourths vote for voluntary membership would be sufficient in number to make Article XIII unnecessary and that the referendum would serve in place of the amendment being presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of the Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken."

3. (Oconto) Unified Membership

Asks that a referendum of all SMS members be held to determine if it is truly the will of the majority of members that membership in the AMA be a requirement for membership in the State and County Societies and if the referendum shows that the membership does not wish this requirement to be in effect, that it be terminated."

4. (Wood) Unified Membership

Asks that "membership in the AMA no longer be a requirement for membership in the State Medical Society of Wisconsin."

5. (Oneida-Vilas) Unified Membership

Asks that "the SMS House of Delegates support the discontinuance of the unified membership rule."

6. (Resident Physicians Section) Dues Structure for Young Physicians

Asks that "physicians entering the State Medical Society directly after completion of a residency or fellowship may pay the SMS dues at rates of 50% the first year, 75% the second year, and 100% thereafter, providing that during at least twelve (12) full calendar months of residency or fellowship the physician was a dues paying member of the AMA or SMS."

7. (LaCrosse) Dues Structure for Young Physicians

Asks that "the State Medical Society alter its dues structure to allow one-half (1/2) dues payment for these young physicians for the first three (3) years out of postgraduate medical education; and that the county medical societies be encouraged to alter their dues structure likewise, and that the State Medical Society encourage the American Medical Association to make similar adjustments in its dues for the first three years after the completion of postgraduate medical education."

8. (Wood) Creation of Senior Membership

"RESOLVED, that a new form of membership be created within the State Medical Society of Wisconsin called the SENIOR MEMBERSHIP for physicians who have reached the age of 65 before January 1 and have changed from full-time to part-time practice, upon application of the physician, approval of the county medical society, and payment of $100.00 in annual dues to the State Medical Society."

9. (LaCrosse) Alternative Methods of Dues Collections

Asks that "the State Medical Society investigate the possibility of alternative methods of dues collections such as monthly or quarterly payments in order to relieve the burden of a year-end large lump sum payment; and that State Medical Society encourage the American Medical Association to do likewise.

10. (Section on Public Health and Preventive Medicine) World Medical and Health Affairs

Asks that "the State Medical Society of Wisconsin request the American Medical Association to rejoin the World Medical Association and generously support both the American Association for World Health and the United States Committee for the World Health Organization in their commendable efforts on behalf of us all to improve world health and international medical cooperation; and be it further that the State Medical Society of Wisconsin annually invite members to voluntarily add an amount (currently $25) to their county, state and national dues to cover individual membership in the World Medical Association."

11. (Jefferson) Duplication by State Medical Society of Wisconsin and Wisconsin Physicians Alliance

"RESOLVED, that action be initiated at once to unify the State Medical Society of Wisconsin and the Wisconsin Physicians Alliance into one more efficient, and therefore a 'less expensive' body so as to provide the physician of the State of Wisconsin with a more favorable 'cost/benefit' ratio for his dollar spent on 'dues'."

12. (Kenosha) Wisconsin Physicians Service

Directs the Council of the State Medical Society to "take immediate action to divest itself of any corporate relationship with Wisconsin Physicians Service Insurance Corporation."

13. (Oneida-Vilas) Wisconsin Physicians Service

Asks that the "House of Delegates direct that the Council divest the State Medical Society of any and all authority or responsibility for WPSIC and arrange that this be vested in the Board of Directors of WPSIC."

14. (Wood) Wisconsin Physicians Service

"RESOLVED, that the State Medical Society of Wisconsin proceed to separate itself from the WPS at the earliest possible date."

15. (Fond du Lac) Wisconsin Physicians Service

Asks that "the House of Delegates go on record stating that in its opinion the State Medical Society should divest itself of any and all authority or responsibility for WPSIC."

16. (Manitowoc) Wisconsin Physicians Service

"RESOLVED, that the State Medical Society retain the logo and the name WPS."

17. (Trempealeau-Jackson-Buffalo) Wisconsin Physicians Service

"RESOLVED, that the State Medical Society sever all relations with Wisconsin Physicians Service Insurance Corporation (WPSIC) completely and as soon as possible."

18. (Sheboygan) Wisconsin Physicians Service

"RESOLVED, that the State Medical Society divorce itself from the Wisconsin Physicians Service Insurance Corporation."

19. (Wood) Current Procedural Terminology IV

"RESOLVED, that CPT IV be adopted by the State Medical Society of Wisconsin as the singular numerical insurance coding method and be supported with all third party carrier negotiations and discussions."

20. (Jefferson) Insurance Company Influences on Medical Practice Trends

Asks that "the State Medical Society of Wisconsin demand recall by those insurance companies of those lists as they constitute usurpation of state's rights, county rights and individual practitioners' rights to decide which medical services should be allowed and which should not."

21. (Jefferson) Equal Payment Policies by Insurance Companies

"RESOLVED, that the State Medical Society of Wisconsin advocates an 'equal payment policy' by insurance companies to guarantee that services rendered in the physician's office will be paid for on the same basis as they would be in the hospital, including payment for the physician's service, any supplies required, and for the space required to perform those services."

22. (Jefferson) Free Choice of Physician

Asks that "the closed panel Health Maintenance Program such as exists in Dane County be abolished, and that the State Medical Society of Wisconsin expose any other similar program which restricts the patient's freedom of choice of physicians.

23. (Wood) Mental illness coverage under National Health Insurance

"RESOLVED, that the State Medical Society of Wisconsin petition the American Medical Association to delete any such differences from National Health Insurance programs it sponsors."

24. (Fond du Lac) Doctor-patient relationship

"RESOLVED, for the safety and health of our patients, that the State Medical Society of Wisconsin, in conjunction with other medical societies, make an urgent and strong attempt to rescind current rules and regulations and oppose future rules and regulations that interfere with the doctor-patient relationship."

25. (Waukesha) Physicians' office records

Asks that "the State Medical Society appraise its members of the successful battle against HEW invasion of doctors' offices in California; and be it further, that the State Medical Society keep its ear turned to this threat and have ready a legal plan of action to preserve and protect the Wisconsin physician from any and all violation of the physician's office by federal or state agents."

26. (Dane) Peer review: private vs. federal

"RESOLVED, that the State Medical Society organize and support a statewide non-membership medical foundation responsible for coordinating and accomplishing all medical review activities, other than those that have been governmentally mandated (PSROs).

27. (District I Delegation) Commendation of Acting Governor Schreiber

Asks that "this House of Delegates officially commend Acting Governor Schreiber for his veto of SB 108

(mandatory insurance coverage of chiropractic), as well as those Senators who sustained this veto."

28. (Section on Public Health and Preventive Medicine) Financial support for local health departments

"RESOLVED, that additional financial support be provided for preventive medicine and health education; and be it further, that the State Medical Society request the Governor and the Legislature to provide financial support for local health agencies."

29. (Fond du Lac) Deposition vs. court appearance in civil procedures

Asks that "the State Medical Society encourage and back the introduction of a bill into the State Legislature to amend the Rules for Civil Procedure so that a physician who can show that he has made himself reasonably available for a deposition may quash the service of a subpoena to appear in court."

30. (District I Delegation) Paramedical organizations

"RESOLVED, that the State Medical Society support legislation to put examining boards of paramedical organizations under the direct control of the Medical Examining Board."

31. (District I Delegation) Defined hospital privileges for para-professionals

Asks that "the State Medical Society, in cooperation with the Wisconsin Hospital Association, develop guidelines to assist hospitals in amending their Bylaws so that para-professional personnel may apply for 'affiliate' or other appropriate category of hospital staff membership."

32. (Resident Physicians Section) Housestaff contracts

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin go on record as supporting the concept of resident contracts with the training hospital or institution that shall include specific references, but not be limited, to wages, working hours and conditions, fringe benefits, and a due process clause for disputes; and be it further, that the Board of Trustees and/or SMS staff communicate this policy of the House to all institutions or hospitals in Wisconsin with housestaff training programs."

33. (District I Delegation) Emergency treatment follow-up

Asks that "emergency departments be required to send a report to the patient's private physician for follow-up of all emergency treatment the day after the visit, and that every effort be made at the time of the emergency to contact the private physician and notify him of the situation."

34. (District I Delegation) Hospital bed access

Asks that the "SMS recognize this potential problem and develop guidelines to assist hospital medical staffs and new physicians in dealing with this situation."

35. (District I Delegation) Physical therapy programs accreditation

"RESOLVED, that the State Medical Society of Wisconsin strongly recommends that the AMA, representing America's physicians, urge college presidents, deans of medical and allied health medical schools, appropriate academic administrative officers and directors of physical therapy programs to continue to seek voluntary accreditation from the CAHEA-PT Review Committee, providing a programatic accreditation mechanism representative of the widest community of interests (physical therapists, other allied health practitioners, physicians, hospitals and academic institutions), and which coordinates rather than fragments allied health education accreditation; and be it further, that our State Society write COPA of its support for CAHEA-PT Review Committee accreditation recognition, and urge representatives of other state medical societies to write similar support letters."

36. (District I Delegation) Health screening, treatment, and education programs

Asks that "in the equally important interests of continuity of patient care and reduction of health care costs, the State Medical Society assign its appropriate committee to investigate the problem and make appropriate recommendations toward its solution."

37. (Winnebago) Actions of the Committee on Nominations

"RESOLVED, that it shall be a policy of the State Medical Society of Wisconsin that no member while serving on the Committee on Nominations shall be nominated as a constitutional officer of the Society or as a delegate or alternate delegate to the American Medical Association by the Committee on Nominations."

38. (Oconto) Sponsors of resolutions

Asks that "resolutions which are properly submitted in other respects be given full consideration even in the absence of a sponsor from the County Society sponsoring the resolutions."

39. (District I Delegation) Implementation of House actions

Asks that "effective with the 1979 State Medical Society Annual Meeting, the delegates' materials shall include a synopsis of the previous year's House actions as well as a status report from the Council on the extent to which those actions were put into effect during the year."

40. (District I Delegation) County Medical Society meetings

"RESOLVED, that every county medical society in Wisconsin be encouraged to conduct frequent membership meetings throughout the year, with the State Society staff lending its assistance in this effort; and be it further, that the State Society obtain the minutes of such local membership meetings and report the highlights to all other societies statewide."

41. (District I Delegation) AMA Presidency

"RESOLVED, that the State Medical Society formalize its position that the AMA President be elected by the House of delegates for an appropriate but temporary term, and that a continuing effort be made within AMA to strengthen the role of its President." ■

State Medical Society of Wisconsin

DELEGATES AND ALTERNATES—1977

Counties	Delegates	Corresponding Alternates
FIRST DISTRICT		
KENOSHA	D. N. Goldstein	S. R. Rosen
	J. N. Richards	C. E. Peterson
MILWAUKEE	B. B. Becker	R. T. Adlam
	G. C. Bernhard	S. D. P. Altman
	D. C. Bruno	M. C. Collopy
	D. J. Carlson	J. W. Cornell
	A. C. Costello	S. A. Graziano
	P. A. Dudenhoefer	D. P. Collins
	C. P. Erwin	K. S. Fabric
	W. E. Finlayson	J. W. Fons, Jr.
	G. F. Flynn	M. T. Galang, Jr.
	H. R. Foerster, Jr.	M. T. Jaekels
	G. H. Franke	J. E. Geigler
	Marvin Glicklich	L. B. Glicklich
	T. F. Jennings	S. V. Hansen
	H. M. Kauffman	S. A. Korducki
	P. G. LaBissoniere	E. J. Drvaric
	R. E. Laubenheimer	H. W. Parker
	J. D. Levin	D. K. Dunn
	R. F. Madden	J. A. Chopyak
	J. A. Means, III	M. D. Poland
	J. P. Mullooly	R. E. Pollard
	G. V. Murphy	J. L. Grieshop
	A. R. Pequet	Louis Kagen
	R. B. Pittelkow	J. V. Pilliod
	Shimpei Sakaguchi	Richard Stone
	K. E. Sauter	B. H. Usow
	D. P. Schlueter	George Walcott
	J. T. Schmitz	S. F. Horwitz
	K. M. Smigielski	J. J. Sherry
	W. L. Treacy	J. D. Storey
	H. F. Twelmeyer	D. J. Welter
	Marvin Wagner	P. J. Taugher
	R. R. Watson	J. L. Teresi
	DeLore Williams	G. J. Topetzes
	J. F. Zimmer	Maxwell Weingarten
OZAUKEE	R. F. Henkle	J. E. Kippenhan
RACINE	L. R. Grinney	K. H. Kolmeier
	M. G. Parker	S. M. Englander
	W. J. Smollen	J. J. Veranth
WALWORTH	I. J. Bruhn	R. S. Galgano
WASHINGTON	C. S. Geiger, Jr.	Parnell Donahue
WAUKESHA	T. P. Belson	R. J. Darling
	R. P. Froeschle	J. C. Hanson
	T. A. Hofbauer	K. J. Dempsey
	G. D. Miller	M. A. Meyer
	J. D. Riesch	W. H. Konetzki
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	R. T. Cooney	M. L. Janssen
DANE	J. G. Albright	Sanford Mackman
	J. C. Allen	S. W. Boyer
	J. F. Batson	B. E. Stein
	M. A. Cunningham	P. P. Rank
	C. H. Geppert	C. L. Andringa
	E. E. Johnson	R. A. Graf
	T. C. Meyer	R. J. Hendricks
	J. N. Moore	C. A. Neuhauser
	V. W. Nordholm	Phillip Schoenbeck
	J. K. Scott	J. B. Davis
	R. W. Shropshire	W. J. Hisgen
	P. O. Simenstad	F. H. Koenecke, Jr.
	C. A. Taylor, Jr.	J. D. Kabler
	C. B. Weston	L. C. Bernhardt
DODGE	W. E. Funcke	F. A. Karsten
GRANT	S. J. Nuland	K. L. Bauman
GREEN	M. S. Blumenthal	J. E. Erlandson
IOWA	T. A. Correll	H. P. Breier
JEFFERSON	D. E. Bates	R. R. Liebenow
LAFAYETTE	L. L. Olson	N. A. McGreane
RICHLAND	J. J. Tydrich	R. W. Edwards
ROCK	Jordon Frank	R. M. Baldwin
	M. F. Purdy	A. L. Reinardy
	Vacancy	Vacancy
SAUK	I. A. Galarnyk	G. J. Holmen
THIRD DISTRICT		
CRAWFORD	E. M. Desslock	Vacancy
JUNEAU	V. M. Griffin	Jack Strong
LA CROSSE	D. B. Comin	Frederick Skemp
	J. T. Murphy	K. P. Grill
	C. A. Natoli	S. B. Webster
	D. W. Taebel	K. L. Newcomer
MONROE	J. S. Mubarek	P. G. Albrecht
TREMPEALEAU-JACKSON-BUFFALO	W. E. Wright	J. H. Noble
VERNON	R. A. Starr	T. E. Boston
FOURTH DISTRICT		
CLARK	B. O. Gungor	E. D. Pfefferkorn
FOREST	B. S. Rathert	E. F. Castaldo
LANGLADE	J. O. Moermond, Jr.	T. C. Fox
LINCOLN	N. L. Bugarin	J. S. Janowiak
MARATHON	G. R. Hammes	T. O. Miller
	J. D. Kramer	W. B. Rudy
ONEIDA-VILAS	H. J. C. Schwartz	W. E. Raduege
PORTAGE	P. K. Hacker	B. C. Palaganas
PRICE-TAYLOR	W. W. Meyer	Vacancy
WOOD	R. L. Hansen	W. J. Maurer
	R. L. Johnson	J. E. Thompson
	R. H. Ulmer	W. M. Toyama
	Vacancy	Vacancy
FIFTH DISTRICT		
CALUMET	R. D. Heinen	J. L. Jaeck
FOND DU LAC	J. T. Elliott	L. C. Fischer
	R. S. Pelton	B. H. Hartman
GREEN LAKE-WAUSHARA	R. A. Kjentvet	Roy Hong
OUTAGAMIE	M. K. Jasser	C. F. Dungar
	R. R. Kinde	R. W. Swanson
	R. H. Ward	K. N. Keane
WAUPACA	L. P. Maasch	D. M. Lochner
WINNEBAGO	G. W. Arndt	G. R. Anderson
	J. L. Basiliere	J. A. Mathison
	T. T. Flaherty	O. E. Larson
	K. M. Viste, Jr.	C. R. Lyons
SIXTH DISTRICT		
BROWN	J. E. Martin	L. D. Philipp
	W. E. McNeal	G. R. Kaftan
	C. W. Troup	J. A. McIntyre
	B. P. Waldkirch	Roger von Heimburg
DOOR-KEWAUNEE	J. J. Beck	D. E. Papendick
MANITOWOC	G. H. Stannard, Jr.	J. D. Lynch
MARINETTE-FLORENCE	C. E. Koepp	R. C. Murray
OCONTO	J. K. Theisen	C. E. Siefert
SHAWANO	W. W. Grover	J. J. Albright
SHEBOYGAN	J. B. Kuplic	I. L. Schroeder
	R. M. Senty	R. C. Pauly
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	J. L. Esswein	F. M. Bannister
CHIPPEWA	M. W. Asplund	J. J. Sazama
EAU CLAIRE-DUNN-PEPIN	R. F. Hudson	P. J. Happe
	K. E. Walter	Vacancy
	J. E. Willard	S. R. Lee
PIERCE-ST. CROIX	J. A. May	D. M. Woeste
POLK	Vacancy	M. E. Wegner
RUSK	J. E. Murphy	R. P. Bennett
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	J. M. Jauquet	H. H. Larson
DOUGLAS	C. M. Scott	T. J. Doyle
SAWYER	M. H. Sahs	Vacancy
SECTIONS		
ALLERGY AND CLINICAL IMMUNOLOGY	J. J. Ouellette	S. R. Hirsch
ANESTHESIOLOGY	J. T. Small	W. J. Holtey
DERMATOLOGY	J. E. Taxman	H. V. Moss, Jr.
FAMILY PHYSICIANS	N. G. Bauch	J. O. Grade
INTERNAL MEDICINE	G. E. Owen	B. J. Haza
MEDICAL FACULTIES	Vacancy	R. A. Pattillo
NEUROLOGY	Francis Kruse, Sr.	Michael McQuillan
NEUROSURGERY	G. A. Meyer	F. C. Kriss
OBSTETRICS-GYNECOLOGY	W. E. Martens	R. P. Reik
OPHTHALMOLOGY	R. W. Pointer	T. W. Stram
ORTHOPEDICS	P. A. Jacobs	G. N. Guten
OTOLARYNGOLOGY	M. F. Kwaterski	Vacancy
PATHOLOGY	E. A. Burg, Jr.	R. E. Carlovsky
PEDIATRICS	R. L. Myers	W. H. Bartlett
PHYSICAL MEDICINE AND REHABILITATION	S. A. Spicuzza	J. A. Sladky
PLASTIC SURGERY	J. E. Hamacher	G. M. Tucker
PSYCHIATRY	D. A. Treffert	Craig Larson
PUBLIC HEALTH AND PREVENTIVE MEDICINE	G. P. Ferrazzano	Richard Biek
RADIOLOGY	R. C. Feulner	Vacancy
RESIDENTS	Vacancy	Vacancy
SURGERY	T. J. Beno	G. F. Pratt
UROLOGY	F. I. Andres	Raymond Harkavy

State Medical Society of Wisconsin

1978 ANNUAL MEETING

Thursday-Friday-Saturday

April 13-14-15/Milwaukee

Milwaukee Exposition & Convention Center & Arena (MECCA)

Headquarters Hotel: The Marc Plaza (MP)

TIMETABLE

THURSDAY MORNING/April 13

8:00-12:30 *Cost Containment and the Physician* —Seminar (MP)

9:00 Breakfast and Meeting: Board of Directors, Wisconsin Academy of Family Physicians (MP)

10:30 Section Delegates Caucus (MP)

THURSDAY AFTERNOON/April 13

1:00 Registration House of Delegates (MECCA)

2:00 First Session House of Delegates (MECCA)

5:30 WISPAC Reception and Dinner (MP)

THURSDAY EVENING/April 13

7:30 Open Hearing AMA Delegates (MP)

7:30 Reference Committee Meetings (MP)

FRIDAY MORNING/April 14

7:15 Medicine and Religion Breakfast: Catholic Physicians Guild (MP)—*Ethics in Medicine*, by Norman C Fost, MD, Department of Pediatrics, UW Center for Health Sciences

8:30-10:00 Panel on *Health Planning—HSA-Statewide Impact* (MECCA)

9:00-10:20 Panel on *Health Maintenance* (MECCA)

9:00-12:00 Resident Physician Section/Business Session (MECCA)

9:00-11:00 Otolaryngology/Wet Clinic (Veterans Administration Hospital/Wood)

10:00 12:00 Panel on *Home Deliveries* (MECCA)

10:00-12:00 Plastic surgery (MECCA)

FRIDAY AFTERNOON/April 14

12:15-1:45 Socio-economic Luncheon: *Hippocrates and Sisyphus: The Odd Couple* (*Bureaucratic Rounds*), by Mr Donald E Percy, Secretary, Wisconsin Department of Health and Social Services (MECCA)

12:15 Plastic Surgery Luncheon (MECCA)

12:15 Radiation Oncology Luncheon (MECCA)

12:45-1:30 Radiation Oncology (MECCA)

1:00-3:30 Plastic Surgery (continuation of morning program) (MECCA)

1:30-3:00 Otolaryngology (continuation of morning program) (MECCA)

1:45-4:45 Panel on *Pediatric Malignancy* (MECCA)

1:45-4:30 Resident Physician Section/Plenary Session (continuation of morning program) (MECCA)

2:00-3:00 Public Health and Preventive Medicine (MECCA)

2:30-4:00 *Medical Audit Revised: Some New Variations on an Old Theme*, by Foundation for Medical Care Evaluation and Wisconsin Professional Review Organization (MECCA)

3:00 Business Meeting: Wisconsin Otolaryngological Society (MECCA)

3:00 Business Meeting: Public Health and Preventive Medicine (MECCA)

3:00 Registration House of Delegates (MECCA)

3:30-4:30 Annual Business Meeting: Wisconsin Society of Plastic Surgeons (MECCA)

4:00 Second Session House of Delegates (MECCA)

FRIDAY EVENING/April 14

6:00 Social Hour/Dinner: Wisconsin Society of Plastic Surgeons (Milwaukee Athletic Club)

6:00 Dinner: Ophthalmology (Milwaukee Club)

6:30 Presidents Reception (MP)

7:30 Presidents Dinner (MP)
Entertainment: *The Wisconsin Singers*

continued on next page

SATURDAY MORNING/April 15

7:30 Breakfast and Meeting: Aesculapian Society (MP)

7:30 Registration House of Delegates (MECCA)

8:00 Third Session House of Delegates (MECCA)

8:00-12:00 Surgery (St Luke's Hospital)

8:30 Breakfast/Meeting: Nuclear Physicians (MP)

8:30-10:00 *Political Action*, by WISPAC and Physicians Alliance Commission (MECCA)

9:00-10:20 Panel on *Methods of Pain Control* (MECCA)

9:00-12:00 Ophthalmology (MECCA)

9:30-12:00 Pathology (MECCA)

9:30-12:00 Radiology (MECCA)

10:30-12:00 *The 1977-79 Legislature: An Analysis and Review*, by Commission on Governmental Affairs (MECCA)

10:30-12:00 Council Meeting (MP)

12:00 Luncheon: Council and Past Presidents (MP)

SATURDAY AFTERNOON/April 15

12:15 Luncheons (followed by afternoon programs)

- Allergy and Clinical Immunology (MECCA)
- Anesthesiology (Business Meeting: Section on Anesthesiology and Wisconsin Society of Anesthesiologists) (MECCA)
- Dermatology (MECCA)
- Emergency Medicine (MECCA)
- Internal Medicine (MECCA)
- Orthopedics (MECCA)
- Physical Medicine and Rehabilitation (MECCA)
- Surgery (Public Affairs Panels) (St Luke's Hospital)

12:30 Pathology Luncheon (MECCA)

12:45 Radiology Luncheon (MECCA)

12:45 Ophthalmology Luncheon (MECCA) (Business Meeting: Section on Ophthalmology)

1:00-4:30 Internal Medicine (MECCA)

1:00-4:45 Physical Medicine and Rehabilitation (MECCA)

1:30-2:00 Business Meeting: Section on Pathology (MECCA)

1:30 Business Meeting: Wisconsin Radiological Society (MECCA)

1:30-5:00 Surgery (MECCA)

1:45-4:30 Dermatology (MECCA)

2:00-3:30 Allergy and Clinical Immunology (MECCA)

2:00-3:30 Emergency Medicine (MECCA)

2:00-4:30 Orthopedics (MECCA)

2:00-5:00 Pathology (MECCA)

2:30-4:45 Radiology (MECCA)

3:00-4:00 Anesthesiology (MECCA)

3:30 Business Meeting: Wisconsin Chapter, American College of Emergency Physicians (MECCA)

4:00 Business Meeting: Wisconsin Allergy Society (MECCA)

4:30 Business Meeting: Wisconsin Orthopaedic Society (MECCA)

4:30 Business Meeting: Wisconsin Society of Internal Medicine (MECCA)

5:00 Business Meeting: Wisconsin Surgical Society (MECCA)

SATURDAY EVENING/April 15

6:00 Dinner: Wisconsin Orthopaedic Society (Milwaukee Athletic Club)

6:30 Social Hour/Dinner: Wisconsin Society of Internal Medicine (MP)

— Evening Dinner: Wisconsin Surgical Society (Milwaukee Athletic Club) ■

Toll-free WATS line for members: 1-800-362-9080

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 AM and 4:30 PM weekdays. Keep this number handy for easy reference! The SMS staff welcomes this additional service in making it more accessible to members.

REGISTRATION

There will be a registration fee of $25 for all physicians who are nonmembers of the State Medical Society of Wisconsin, payable at the time of registration at the registration desk, first floor, MECCA. Medical students, residents, interns, and out-of-state physicians, who are members of their appropriate state medical associations, are exempt from this fee.

ACKNOWLEDGMENT OF GRANTS

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin acknowledges with appreciation grants made to it by:

Graf's Beverages
Coca-Cola, USA
Pitney Bowes
A H Robins Company

for continuing education of physicians. Under the direction of the Foundation, these grants have been utilized for support of the scientific program of the 1978 Annual Meeting of the State Medical Society of Wisconsin.

COST CONTAINMENT AND THE PHYSICIAN

Thursday, April 13/8:00 am - 12:30 pm

Crystal Ballroom/Marc Plaza Hotel

The costs of medical care continue to rise at an extraordinary rate. Many factors are contributing to this rise, but perhaps the most important factor is the physician's contribution to these costs.

This participatory conference is designed to examine the roles of the physician as an individual and collectively in the containment of medical care costs. The expectation is that registrants will take away with them an acute understanding of their own unique roles in the containment of costs as well as a better understanding of the efforts of outside agencies in attempting to reduce the rate of rise of costs of ill-health.

Presented by UW-Madison School of Medicine; UW-Extension Health Sciences Unit, Department of Continuing Medical Education; in cooperation with the State Medical Society of Wisconsin and Wisconsin Hospital Association.

REGISTRATION FEE: $18.00

ADVANCE REGISTRATION REQUIRED

For further details, contact Barbara Wermuth at 608/263-2852; or make your check of $18.00 payable to COST CONTAINMENT PROGRAM, and mail to: UW-Extension, CME Coordinator, The Wisconsin Center, 702 Langdon Street, Madison, Wis 53706. You will be furnished a detailed program. Be sure to include the following information along with your check: NAME — ADDRESS — CITY — STATE — ZIP — OFFICE PHONE NUMBER.

PANELS with Category I credit

The following April 14 (Friday) panels are accredited through the State Medical Society of Wisconsin for Category I credit of the PRA of the AMA and prescribed American Academy of Family Physicians credit (AAFP):

Panel on **Health Maintenance** ..... 1½ hours

Panel on **Home Deliveries** ..... 1½ hours

Panel on **Pediatric Malignancy** .....3 hours

Documentation of attendance will be provided participants at the end of each session.

MEDICAL AUDIT REVISED: SOME NEW VARIATIONS ON AN OLD THEME

Friday, April 14, in Room W-10/MECCA, from 2:30 to 4:00 pm. Cosponsored by the Foundation for Medical Care Evaluation and Wisconsin Professional Review Organization. A panel composed of physicians from small, medium, and large sized hospitals will discuss medical audit with emphasis on how to make changes and improvements based on medical audit and following up on action taken. There will be a brief overview of audit methodology followed by examples of both successful audits and "flops." Resources will be available.

PANELS with Category I credit

The following Saturday, April 15, panels are accredited through the State Medical Society of Wisconsin for Category I credit of the PRA of the AMA and prescribed American Academy of Family Physicians credit (AAFP):

Panel on **Methods of Pain Control** ....1½ hours

Panel on **The Emergency Patient** .....1½ hours

Documentation of attendance will be provided participants at the end of each session.

COMPLETE ANNUAL MEETING PROGRAM

In mid-March SMS members were sent the complete 1978 Annual Meeting Program. Please refer to this Program for further particulars. Anyone wishing an additional Program may call the SMS offices on the toll-free in WATS line: 1-800-362-9080 (calls must originate in Wisconsin). Physicians are requested to bring their Annual Meeting Programs with them. Also the TIMETABLE in this issue can be clipped and placed with the PROGRAM for a concise outline of the scheduled times for each event.

HOUSE OF DELEGATES

The House of Delegates meetings are regarded as among the most important functions of the Society. Reports of the officers and committees, as well as new business, will be presented at the initial session on Thursday afternoon, starting at 2:00. Reference committees will meet Thursday evening at 7:30, with reports to be made at the Friday afternoon session, starting at 4:00. The third session, with election of officers, and installation of the President, will be held on Saturday morning, starting at 8:00. Registration of delegates and alternates precedes the first and second sessions by one hour, the third session by one-half hour. Society members are urged to participate in the discussions on reports and resolutions in the open hearings of the reference committees. A summary of the resolutions appears elsewhere in this issue. Nominees for Society offices were announced in the February issue, with a biographical sketch of each. Delegates and alternates, officers, councilors, and commission/committee chairmen have received the House of Delegates HANDBOOK containing reports and resolutions to be submitted to the House. These will be discussed at the District Caucuses being held during March and April, preceding the Annual Meeting.

SCIENTIFIC PROGRAM PLANNERS

Commission on Continuing Medical Education

Warren J Hotley, MD, *Chairman*, Marshfield

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Adolf Gundersen Medical Foundation & La Crosse Lutheran Hospital, La Crosse
Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Deaconess Hospital, Milwaukee
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Methodist Hospital, Madison
Memorial Hospital, Menomonie
Osseo Area Municipal Hospital, Osseo
Sacred Heart Hospital, Eau Claire
Sauk Prairie Memorial Hospital, Prairie du Sac
St Agnes Hospital, Fond du Lac
St Clare Hospital, Baraboo
St Francis Hospital, La Crosse
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Vincent Hospital, Green Bay
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospitals, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

American Heart Association, Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
State Medical Society Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolarynogological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Critical Care Medicine
Wisconsin Society of Obstetrics & Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

AMA Accredited

Dept. CME, Medical College of Wisconsin
Dept. CME, UW Medical School
Wisconsin Society of Anesthesiologists
The State Medical Society of Wisconsin

MAYO ALUMNI MEETING

A Mayo Alumni Meeting will be held on Thursday, April 13. Attendance is by invitation. Guest speaker is Richard A DeRemee, MD of the Mayo Clinic, Rochester, Minn. Further details are unavailable at this printing.

STITCHERY SHOW

The Aesculapian Society of the SMS Charitable, Educational and Scientific Foundation is sponsoring a Stitchery Show on Saturday, April 15, from 10:00 am until 2:00 pm on the fifth floor lobby of the Marc Plaza Hotel. Doctors and their spouses may exhibit any stitchery, old or new, or just come to admire what others have made.

SCIENTIFIC EXHIBITS

(Sponsoring institution(s) followed by title of exhibit(s)

COLUMBIA HOSPITAL, MILWAUKEE

Magnification Radiography
Muscle Histochemistry and Teased Nerve Fiber Preparations in Neuromuscular Diseases
Prosthetic Joints in the Rheumatoid Hand

MEDICAL COLLEGE OF WISCONSIN, MILWAUKEE

Frequency and Significance of Occult Metastasis in Breast Cancer (Dept. of Pathology & National Cancer Institute)
Histopathology of Involuting Warts
Information Services for Wisconsin Physicians (Library, Medical College of Wisconsin; UW Middleton Medical Library, Madison)

MILWAUKEE CHILDREN'S HOSPITAL, MILWAUKEE

Management of the Transposition of the Great Arteries (Fairchild Cardiac Study Center)
Magnification Angiography in Pediatric Vascular Disease (Dept. of Radiology)
Metrizamide Myelography in Pediatrics (Dept. of Radiology)
Normal and Abnormal Auditory Responses in Neonates and Infants (Dept. of Audiology)

UW CENTER FOR HEALTH SCIENCES, MADISON

Pain Management (Children's Hospital)
Physician Assistant Program (UW-Madison, School of Allied Health Professions)
Spinal Cord Injury Center (Children's Hospital)

TECHNICAL EXHIBITS

AMEDD Personnel Procurement, Ft Sheridan, IL
Ames Company, Elkhart, IN
Boehringer-Inglehelm Ltd, Elmsford, NY
Bristol Laboratories, Syracuse, NY
Burroughs Wellcome Company, Research Triangle, NC
Cooper Laboratories, Parsippany, NJ
Encyclopaedia Britannica, Chicago, IL
Fisons Corporation, Bedford, MA
Hoechst-Roussel Pharmaceuticals Inc., Sommerville, NJ
International Business Machines Corporation, Milwaukee, WI
Kremers-Urban Company, Milwaukee, WI
Lederle Laboratories, Pearl River, NY
Eli Lilly & Company, Indianapolis, IN
Marion Laboratories Inc., Kansas City, MO
McNeil Laboratories Inc., Ft Washington, PA
Mead Johnson Nutritional Division, Evansville, IN
Mead Johnson Pharmaceutical Division, Evansville, IN
Medical Placement Services, Milwaukee, WI
Medical Plastics Laboratory, Gatesville, TX
The Medical Protective Company, Ft Wayne, IN
Merck Sharp & Dohme, West Point, PA
METPATH, Milwaukee, WI
Meyer Laboratories Inc., Ft Lauderdale, FL
Mutual Benefit Life Insurance Company, Milwaukee, WI
Ortho-Kinetics, Waukesha, WI
Ortho Pharmaceutical Corporation, Raritan, NJ
Parke Davis & Company, Detroit, MI
Purdue Frederick Company, Norwalk, CT
Reed & Carnrick Pharmaceuticals, Kenilworth, NJ
Rowell Laboratories Inc., Baudette, MN
Sandoz Pharmaceuticals, Hanover, NJ
Searle Laboratories, Chicago, IL
The Seefurth-McGivern Corporation, Milwaukee, WI
Smith Kline & French Laboratories, Philadelphia, PA
E. R. Squibb & Sons, Princeton, NJ
Stuart Pharmaceuticals, Wilmington, DE
Surgical Care-Blue Shield, Milwaukee, WI
Syntex Laboratories Inc., Palo Alto, CA
Telemed Corporation, Hoffman Estates, IL
United Medical Research Inc., Costa Mesa, CA
US Air Force Medical Procurement Division, Milwaukee, WI
US Navy Medical Recruiting, Milwaukee, WI
USV Laboratories, Tuckahoe, NY
Warner/Chilcott, Morris Plains, NJ
Warren-Teed Laboratories, Inc., (Div. of Adria Laboratories), Columbus, OH
Wisconsin Physicians Service Insurance Corporation, Madison, WI
Harold J. Westin Associates, St. Paul, MN
Westland Software House Inc., Winnetka, CA

NEWS HIGHLIGHTS

East Madison Clinic

. . . is the first clinic in Madison to receive a four-year Accreditation for Ambulatory Health Care under the Joint Commission on Accreditation of Hospitals. A similar accreditation has been required of hospitals for a number of years, but until recently it was considered too difficult to assess outpatient clinic care. All medical offices soon will be required to have such accreditation, according to William Rock, MD,* president of the Clinic. The East Madison Clinic's group practice consists of 29 physicians at the main clinic, and four serving the satellite clinic in Sun Prairie.

New Staff Officers

. . . recently were elected to the medical staff of West Allis Memorial Hospital. MDs elected are John W Bowman,* secretary-treasurer; Robert D Bahr,* chief of in-service; Robert R Komar,* chief of general practice; Armin R Baier,* chief of internal medicine; and Lawrence L Foster,* chief of orthopedics. They will serve two-year terms.

Clinical Nutrition Program

. . . at the University of Wisconsin-Madison campus started in January with the opening of a new Clinical Nutrition Center. Dr Earl Shrago, director of the Center and professor of medicine and nutritional science, says the Center will initiate courses and seminars in nutrition for medical and graduate students, University Hospitals physicians, and other UW healthcare professionals. Currently, nutrition courses are not part of the medical school curriculum.

Additionally the Center Faculty will conduct and sponsor basic and clinical research on problems such as obesity, diabetes, heart disease, and nutritional needs of the critically ill.

The Clinical Nutrition Center is housed in the Department of Nutritional Sciences. It is jointly sponsored by the Schools of Medicine and Agricultural and Life Sciences and is funded by a half million dollar grant from the Wisconsin Alumni Research Foundation (WARF) to the Graduate School of the University. ■

PHYSICIAN BRIEFS

Kathryn C Bemmann, MD*

. . . Waukesha, has been appointed to the Professional Resources Committee of the American Medical Women's Association. Doctor Bemmann, an active member of AMWA, is the president and founder of the Association's Southeastern Wisconsin branch, centered around the Medical College of Wisconsin.

The Professional Resources Committee receives all requests and suggestions for appointments to special panels on various specialties called for by the President of the United States, governmental agencies, or other health-related agencies.

In addition to the Professional Resource Bank, AMWA offers its members a Speakers Bureau, a monthly journal, reaching 22,000 medical women, and membership in the Medical Women's International Association. It maintains a Medical Education Loan Fund and develops and distributes thousands of pieces of career literature each year encouraging qualified women to consider a career in medicine.

Doctor Bemmann received her MD degree from the Medical College of Wisconsin, and continued her medical training with a general rotating internship at St Joseph's Hospital, Milwaukee, and a three-year psychiatric residency at the Associated Psychiatric Training Program of Milwaukee, Milwaukee Psychiatric Hospital.

Pierce J Meier, MD*

. . . radiologist at Watertown Memorial Hospital, recently was the guest speaker of the Jefferson County Medical Assistants monthly meeting. Presenting a program using visual aids and case x-rays, Doctor Meier discussed breast x-ray on mammography.

Geoffrey C Kloster, MD*

. . . Merrill, recently was elected president of the medical staff at Holy Cross Hospital. A member of the Family Medical Clinic, Merrill, Doctor Kloster replaces Michael Mikkelson, MD* who was elected vice-president. M Yusof Ahmad, MD* was elected secretary-treasurer.

Marvin Wagner, MD*

. . . is the new president of The Milwaukee Academy of Surgery. Other MDs elected are Marvin Glicklich,* secretary-treasurer; Allen Savitt,* for the council; and John Reisch, recorder.

Ricardo S Obcena, MD*
Romulo M Sanchez, MD

. . . Cadott physicians, recently purchased the medical clinic at Boyd, and have extended their medical service to that area. Doctor Obcena received his medical degree in The Philippines, interned at St John's Riverside, Yonkers, New York, and spent five years at Weiss Memorial Hospital, Chicago. He entered practice in Cadott in 1971 and is affiliated with St Joseph's, Chippewa Falls, and Sacred Heart hospitals, Eau Claire. Doctor Sanchez also received his medical degree in The Philippines, served a rotating internship at Swedish Covenant Hospital, Chicago, a fellowship training at Missouri State Chest Hospital, and his residency training at Swedish Covenant Hospital, Chicago. He became associated with Doctor Obcena in 1976. Doctor Sanchez is on the medical staff of St Joseph's and Sacred Heart hospitals.

Peter Rank, MD

. . . Madison radiologist, recently was elected president of the Methodist Hospital medical staff. Other new officers are MDs Sanford Mackman,* vice-president; Allen J Pois,* secretary-treasurer, and Gordon I Garnett,* representative to the Dane County Medical Society.

Michael C Gordon, MD*

. . . recently opened his office for the practice of family medicine in the Town of Fitchburg. He is a graduate of the University of Illinois School of Medicine, Chicago, and completed his internship at the University of Wisconsin, Madison. Doctor Gordon is a member of the medical staffs of Methodist and St Mary's hospitals in Madison. He also is active in the treatment of alcoholism and chemical dependency and is affiliated with the Anderson Rehabilitation Hospital in Janesville.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

James E Youker, MD*

. . . director of radiology at the Milwaukee County Medical Complex, recently was named president of the professional staff. He succeeds John A Arkins, MD.* Doctor Youker also is chairman of the Department of Radiology at the Medical College of Wisconsin.

Ray Thorpe, MD*

. . . of the Wausau Medical Center, recently received certification by the American Board of Radiology. A 1968 graduate of Cornell University Medical College, his residency training was from 1974 to 1977 at the University of Utah Medical Center, Salt Lake City. He has been a member of the staff of Wausau Medical Center since 1977.

Harold H Scudamore, MD*

. . . is the new president of the medical staff of St Clare Hospital, Monroe. Doctor Scudamore, an internist and gastroenterologist at The Monroe Clinic since 1971, heads an organization of officers which includes MDs Robert F Wichser,* past president; George R Barry,* president-elect; and Terrence E Peters,* secretary-treasurer. He was a consultant in medicine at the Mayo Clinic and an associate professor of medicine in the Mayo Graduate School of Medicine of the University of Minnesota before joining The Monroe Clinic staff. Doctor Scudamore is a member of the *WMJ* Editorial Board.

Martin A Rammer, MD*

. . . Sheboygan, recently became certified by the American Board of Family Practice. Doctor Rammer, a member of Sheboygan Memorial Hospital's medical staff, has practiced in Sheboygan for the past 12 years.

Robert W DeLorme*

. . . Neillsville, is the family practitioner at the Greenwood Family Medical Center which recently opened. Doctor DeLorme joined the Neillsville Clinic in 1977 after a two-year residency in the McMaster Family Practice Program in Hamilton, Ontario, Canada.

Anatolio G Wasserman, MD

. . . recently joined the Department of Orthopedic Surgery at the Marshfield Clinic. A native of Mexico City, Doctor Wasserman received his medical degree there, and then served his internship and residency at Charity Hospital-Tulane University, New Orleans. He completed a fellowship at Rush-Presbyterian St Luke's Hospital, Chicago, prior to joining the clinic.

Carl R Poley, MD

. . . Green Bay, recently became associated with the Beaumont Clinic. Doctor Poley graduated from the Medical College of Wisconsin and served his internship and residency in obstetrics and gynecology at St Joseph's Hospital, Milwaukee. Prior to moving to Green Bay, Doctor Poley had been in the United States Army for three years and was chief of the obstetrics and gynecology service in West Germany.

David H Bartlett, MD*

. . . Madison, has become associated with the Bone and Joint Surgery Associates, SC. Doctor Bartlett graduated from the University of Wisconsin Medical School and completed his internship at LaCrosse Lutheran Hospital-Gundersen Clinic and his residency at Barnes Hospital, Washington University, St Louis, Mo.

John Herm, MD

. . . recently became associated with the Richland Medical Center. He is a graduate of the University of Wisconsin Medical School and interned at Maricopa County Hospital in Phoenix. Prior to coming to Richland Center, Doctor Herm was an emergency room physician at the Howard Young Medical Center in Woodruff.

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Robert W Edland, MD*

. . . radiologist at the Gundersen Clinic Ltd, LaCrosse, has been elected councilor to the American College of Radiology. He is the representative of the American Society of Therapeutic Radiologists and Radiotherapists in the Americas. Doctor Edland, outgoing national secretary of the society, is clinical professor of therapeutic radiology and oncology at the University of Wisconsin Medical School in Madison.

James R Keuer, MD*

. . . Medford, recently was elected president of the medical staff of Memorial Hospital of Taylor County, Inc. MDs Jerome S Mayersak,* and Danilo Oliveros,* were elected vice-president and secretary, respectively.

Richard E Mansfield, MD

. . . Manitowoc, has joined the medical staff of Holy Family Hospital as the director of the pathology laboratory. He received his medical degree from Oklahoma University Medical School and served his internship and residency in the US Public Health Service, including training in Charity Hospital-Tulane University in New Orleans. Doctor Mansfield is certified by the American Board of Pathologists and prior to joining the medical staff of Holy Family Hospital, was chief, section of clinical pathology and acting chief, department of laboratories at Lovelace-Bataan Medical Center, Albuquerque, NM. ■

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1978

1 Health Care Coalition
3 Peer Review Steering Committee
4 SMS Council
4 Employees' Pension Plan Managing Committee
4 SMS Committee on Economic Medicine
4 SMS Nominating Committee
4 SMS Committee on Evaluation of Delivery and Cost of Medical Care
7 Dane County Medical Society Board of Trustees
8 SMS Commission on Governmental Affairs
8 SMS Committee on Federal Legislation
8 SMS Committee on Environmental Health
9 WisPRO District Review Council
9 T-19 Pediatrics Conference
9 Committee for Study of Surgical Services
10 SMS Commission on Continuing Medical Education
15 Madison Society of OB-GYN
15 T-19 Clinics
16 SMS Commission on Health Facilities and Services
16 Wisconsin Immunization Initiative Coordinating Committee
17 SMS Physicians Alliance Commission
17 SMS Medical Defense Committee
17 WisPRO Nominating Committee
17 Medicaid Conference
21 SMS Committee on Aging and Extended Care Facilities
22 Ad Hoc Committee to Study Quality Care Activities
23 Laboratory Certification Committee
27 HSA Physicians Task Force

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

WPS

report

for Wisconsin Physicians

Volume VII, Number 2 March 1978

PROVIDER EXPLANATION OF BENEFITS

In February, 1977, WPS began sending to subscribers an Explanation of Benefits (EOB) form to notify them of action taken by WPS on their claims. The EOB describes to the subscriber the recipient and provider of service, the place and type of service provided, the amount billed, any deductible applied, and the amount of WPS payment or reason for denial.

Now, in 1978, WPS will introduce an additional informational form called the Provider Explanation of Benefits (PEOB). Like the subscriber EOB, the Provider Explanation of Benefits is a notice of action taken by Wisconsin Physicians Service for services your office provided to our subscribers.

The PEOB gathers together all information on WPS claim actions concerning your patients. In the past, you received a number of different notices and assorted checks from WPS. Now the Provider Expanation of Benefits will bring all that information together into a single document and total all money payable into a single check. To make sure that your office has up-to-date information, WPS will produce both the Provider Explanation of Benefits and payment weekly.

This report lists specific information necessary to keep proper records on your patients: the name of the patient; the WPS subscriber number; the date; place and type of service; the number of services on each given date; the amount billed; the amount of any deductible applied to a specific service; WPS payment for each line item service; and any necessary explanation of WPS action. For each payment the amount billed and the WPS payment are totalled. These figures are placed on the same line as the patient's account number, taken from your claim, allowing easier tracking of this information by your office.

This report will account for all services performed, including services which are paid completely, paid in part or denied. The reasons for partial payment or denial are listed for each service item. The explanations have been written to make them as current, understandable and complete as possible. If your office has any questions on this report, please contact WPS Inquiry Services at (608) 221-4711.

A sample copy of this form appears on the reverse side.

If you have any questions or comments on "Reports," send them to WPS, Communications Division, 1717 West Broadway, Madison, WI 53713.

***Report** is a service to the physicians of Wisconsin.*

and their Medical Assistants

Provider Explanation of Benefits Form

Below is a reduced replica of the Provider Explanation of Benefits form. The actual form is 11" by 14½". The key below, A-Q, will indicate the important areas on the form.

A. Provider Number (to match with check)
B. Control Number (to match with check)
C. Patient's Name
D. WPS Subscriber Number
E. Date of Each Service
F. Place and Type of Service, Coded
G. Number of Services on Each Date
H. Amount Billed
I. Total Amount Billed for Listed Services
J. WPS Allowance
K. Coded Explanation for WPS Allowance
L. Deductible Applied
M. WPS Payment for Each Service
N. Coded Explanation of WPS Payment
O. Total WPS Payment and Date of Payment
P. Patient's Account Number From Your Claim
Q. Explanations of WPS Actions

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PROVIDER EXPLANATION OF BENEFITS

THIS EXPLANATION OF BENEFITS IS INTENDED TO PROVIDE A BETTER UNDERSTANDING OF OUR RESPONSIBILITY FOR CHARGES INCURRED.

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100 Main Street
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15-001 CONTROL = 016-00001 (b)
Page 1 (a)

PLACE OF SERVICE: 1 OFFICE; 2 HOMES/NURSING HOME; 3 - INPATIENT HOSPITAL; 4 EXTENDED CARE FACILITY; 5 - OUTPATIENT HOSPITAL; 6 - INDEPENDENT LABORATORY; 7 - SPECIALTY HOSPITAL; 8 - OTHER

TYPE OF SERVICE: 1 - MEDICAL SERVICES; 2 - SURGERY; 3 - CONSULTATION; 4 DIAGNOSTIC X-RAY; 5 - DIAGNOSTIC LABORATORY; 6 - RADIATION THERAPY; 7 - ANESTHESIA; 8 - ASSISTANCE AT SURGERY; 9 - OTHER; O - DRUGS; L - DENTAL/ORAL SURGERY; M PSYCHIATRIC; S NURSING SERVICES; T - AMBULANCE SERVICE; V - VISION CARE; W APPLIANCE & EQUIPMENT; X - MATERNITY; Y - PHYSICAL THERAPY; Z HMP - NEWBORN

PATIENT'S NAME (c)	SUB NUMBER (d)	DATE OF SERVICE (e)	PLACE (f)	TYPE (g)	NO OF SERVICES	AMOUNT BILLED (h)	WPS ALLOWANCE (j)	SEE BELOW (k)	APPLIED DEDUCTIBLE (l)	WPS PAYMENT (m)	SEE BELOW (n)	PATIENT'S ACCOUNT NUMBER (p)
EVANS DAVID	02410350	10/16/77	3	1	007	343.00				318.00	EE	
		10/16/77	3	1	000	697.75				697.75		
	CLAIM NO.	31108423			TOTAL	***1040.75 (i)				***1015.75		27594
HILL KAREN	02529353	10/20/77	3	1	006	618.00				540.00	KK	
		10/20/77	3	1	000	289.75				289.75		
	CLAIM NO.	30807847			TOTAL	****907.75				****829.75		94372
GOLD ROXANNE	02413292	08/04/77	1	1	001	15.00				.00	54	
		08/04/77	1	5	002	6.00				.00	54	
	CLAIM NO.	29204323			TOTAL	*****21.00				*******.00		39502
LORD NANCY	02000257	09/24/77	8	D	000	81.00				64.80	EE	
	CLAIM NO.	299903999			TOTAL	*****81.00				*****64.80		59305

TOTAL WPS PAYMENT ON 11/11/77 $1910.30 (o)

EE THIS POLICY CONTAINS A DEDUCTIBLE AND/OR COINSURANCE PROVISION WHICH IS THE PATIENT'S RESPONSIBILITY.
KK THIS POLICY PAYS A SPECIFIED ROOM RATE. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN YOUR CHARGE AND THE POLICY'S SPECIFIED ROOM RATE. (q)
54 THIS POLICY DOES NOT PAY FOR PHYSICAL EXAMINATIONS REQUESTED BY A THIRD PARTY.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 Wisconsin

Apr 5: *Head and Neck Cancer Regional Conference,* St Mary's Hospital, Racine. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

Apr 6: *Head and Neck Cancer Regional Conference,* Beloit Memorial Hospital Beloit. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

Apr 6-27: *Diabetes* lectures around the state.

Apr 13-15: SMS Annual Meeting, MECCA, Milwaukee. Headquarters Hotel: Marc Plaza.

Apr 17-June 6: *Independent Study Course in Immunodeficiency Diseases,* by University of Wisconsin Medical School. 26 hours of Category I credit for AMA-PRA. Info: R H Hansen, Continuing Medical Education, 446 WARF Bldg, 610 N Walnut St, Madison, Wis 53706.

Apr 20: *Head and Neck Cancer Regional Conference,* Sheboygan Memorial Hospital, Sheboygan. Info: Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

Apr 28: *Pediatric Anesthesia,* LaCrosse.

Apr 28-29: *Wisconsin Psychiatric Association Annual Scientific Meeting,* at Marshfield Clinic, Marshfield. Friday program: Medical and Psychiatric Utilization of Services. Saturday: Behavorial Change From Four Viewpoints. 10 hours of Category I CEC.

May: Spring Meeting, Wisconsin Neurological Society.

May 5-6: Shareshop on epilepsy—*Practical Modern Approaches to an Ancient Disorder—Epilepsy,* sponsored by Wisconsin Epilepsy Association, University of Wisconsin-Madison Medical School, and UW-Extension, Health Sciences Unit, Department of Continuing Medical Education, at the University Bay Center, Madison. Meets criteria for 16 credit hours in Category I of AMA-PRA. Conference cost for physicians: $70. Further info: Aleta Barmore, Executive Director of the Wisconsin Epilepsy Association, 1245 East Washington Ave, Madison, Wis 53703; tel 608/255-9009.

May 11-13: International conference: *Heart Disease and Rehabilitation—State of the Art 1978,* at the Marc Plaza Hotel, Milwaukee. Presented by Mount Sinai Medical Center (Cardiovascular Disease Section), Milwaukee, in cooperation with the University of Wisconsin-Madison, School of Medicine; the American Heart Association/Wisconsin Affiliate; the UW-Milwaukee, and the Dept of Continuing Medical Education Health Sciences Unit-University of Wisconsin Extension. Program fee $200 for physicians and $75 for nonphysicians. Info: Public Relations Dept, AHA/WA, 795 North Van Buren, Milwaukee, Wis 53202; (414)271-9999.

May 18: *First Annual Spring Cancer Conference* at The Abbey on Lake Geneva, Fontana, Wis. Acceptable for 6 credit hours of Category I of AMA-PRA and 6 credit hours by the AAFP. Info: Registration deadline, May 4, 1978, $10.00 per person. Make check out to Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

May 18-20: *The Family in Treatment: A National Conference on Family Therapy,* Marc Plaza Hotel, Milwaukee. Tuition: $100. Approved for 13 Category I CME Credit Hours and 13 Elective AAFP Credit Hours. Contact: Dr Ross E Carter, Dept of Psychiatry and Mental Health Sciences, Medical College of Wisconsin, 9191 Watertown Plank Road, Milwaukee, Wis 53226.

May 28: University of Wisconsin Commencement, Madison.

May 26: University of Wisconsin Medical Alumni Day, Madison.

May 19-20: *Emergency Problems in Pediatrics,* UW-Madison.

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

The Family in Treatment: a National Conference on Family Therapy

sponsored by the Medical College of Wisconsin, Milwaukee at the Marc Plaza Hotel

Thurs-Sat, May 18-20, 1978

Cosponsors with MCW's Dept of Psychiatry and Mental Health Sciences are Columbia Hospital, Milwaukee Psychiatric Hospital, Milwaukee Mental Health Consultants, and Wood Veterans Administration Center.

Conference is open to psychiatrists, psychologists, social workers, and other allied mental health professionals.

Sixteen different small group seminars on family therapy techniques will be offered including seminars on the treatment of families with hospitalized children, child abusing families, and family therapy with alcohol problems and divorce.

Major addresses include: *The Trained Spontaneity of the Family Therapist,* by Salvador Minuchin, MD, professor of child psychiatry and pediatrics, University of Pennsylvania, and director, Family Therapy Training Center of the Philadelphia Child Guidance Clinic; *The Differentiation of Self,* by Murray Bowen, MD, director of the family center and professor of psychiatry, Georgetown University School of Medicine; and *Therapy with 'Resistant' Families and 'Resistant' Settings,* by Lyman Wynne, MD, PhD, professor of psychiatry, University of Rochester.

Conference has been approved for 13 hours of Category I Credit towards AMA-PRA and program is acceptable for 13 elective hours by AAFP.

Advance registration required. Tuition fee: $100. Info: Ross E Carter, PhD, Director, Division of Family Therapy, Dept of Psychiatry and Mental Health Sciences, MCW, 9191 Watertown Plank Road, Milwaukee, Wis 53226; (414) 964-5100.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

May 1-May 14

Diagnostic Imaging, with Byron G Brogdon, MD, Professor of Radiology, Department of Radiology, University of New Mexico School of Medicine, Health Sciences Center, Albuquerque, New Mexico; Robert H Mosely, Jr, MD, Professor of Radiology, Department of Radiology, University of New Mexico School of Medicine, Health Sciences Center, Albuquerque and Fred A Mettler, Jr, MD, Chief of Diagnostic Imaging, Cancer Research and Treatment Center, Asst Professor of Radiology, Department of Radiology, University of New Mexico School of Medicine, Health Sciences Center, Albuquerque, New Mexico. One hour AMA Cat 1: AAFP Prescribed Credit

May 15-May 28

Hypercalcemia: A Guide to Decision-Making, with Lawrence G Raisz, Professor of Medicine and Head of the Division of Endocrinology and Medicine, University of Connecticut Health Center, Farmington

Face Pain: The Differential Diagnosis and Treatment, with William H Sweet, MD, DSc, Consulting Visiting Neurosurgeon, Massachusetts General Hospital, Professor of Surgerv Emeritus, Harvard Medical School, Boston

May 29-June 11

The New Vegetarians: A Health Food Hype? with Johanna Dwyer, DSc, Director, Frances Stern Nutrition Center, New England Medical Center Hospital, Boston

Giant Cell Arteritis: Diagnosis and Treatment, with Robert C Griggs, MD, Associate Professor, Neurology, Pediatrics, Medicine, Pathology at Strong Memorial Hospital, Rochester, New York

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

1978 NEIGHBORING

Apr 4-5: *Perinatal Medicine: Present and Future Advances* at O'Hare/Kennedy Hotel, Chicago, Ill. Contact: March of Dimes Perinatal Symposium, Metropolitan Chicago Chapter the National Foundation—March of Dimes, 53 West Jackson Blvd, Chicago, Ill 60604. Tel: 312/341-1370. Conference Fee: $75.00. 3/78

Apr 21: *Wisconsin Division of the American Trauma Society* will present a continuing education program. Further details: Charles Aprahamian, MD, President WD-ATS, PO Box 13451, Milwaukee, Wis 53213.

Apr 27-28: *Frontiers in Aging: Life Extension* conference, Radisson-St Paul, Minn. Multidisciplinary conference sponsored by the All-University Center on Aging and conducted by the Department of Conferences at the University of Minnesota. Robert Butler, director of the National Institute on Aging will make the keynote address, "Why Survive 2078?" Info: David Chittenden, Program Director, 219 Nolte Center, 315 Pillsbury Drive SE, University of Minnesota, Minneapolis, Minn 55455; (612)376-2578. g3/78

May 10-12: *Nuclear Medicine for the Internist*, Mayo Clinic and Mayo Foundation, Rochester, Minn. American College of Physicians postgraduate course, approved by AMA Advisory Committee on CME, may be used to fulfill 18½ hours of Category I requirements for AMA-PRA. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia, Pa 19104. g3-4/78

May 22-24: *Hematology Update 1978*, American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

First Annual Spring Cancer Conference

Thursday, May 18, 1978

The Abbey on Lake Geneva/Fontana, Wisconsin

am		
7:30	Registration	
8:00	Welcome—*Paul P Carbone, MD*	
8:05	Pre-Test*—*Paul C Tracy, MD*	
8:30	Reliable Screens—*Richard R Love, MD*	
9:00	Mammography—*Raul H Matallana, MD*	
9:30	Nuclear Medicine—*Robert E Polcyn, MD*	
10:00-11:05	Breast Workshop Group A *Alvin J Greenberg, MD* Chairperson *Robert O Johnson, MD* *Raul H Matallana, MD* *Douglass Tormey, MD*	Lung Workshop Group B *John R Pellett, MD* Chairperson *Ernest C Borden, MD* *Joyce C Kline, MD*
11:10-12:15	Repeat Workshop Group B	Repeat Workshop Group A
pm		
12:30	Luncheon with Guest Speaker *William L Donegan, MD, Surgical Aspects of Early Carcinoma*	
2:00-3:10	Gastrointestinal Workshop Group A *William H Wolberg, MD* Chairperson *Hugh L Davis, MD* *Albert L Wiley, MD*	Gynecology Workshop Group B *Dolores A Buchler, MD* Chairperson *Thomas E Davis, MD* *Mojmir G Sonek, MD*
3:10-4:20	Repeat Workshop Group B	Repeat Workshop Group A

*This program is part of the evaluation process which is required under terms of the NCI grant. Participants will be pre- and post-tested to assist in evaluation of the effectiveness of the conference.

Acceptable for 6 credit hours of Category I of AMA-PRA and 6 credit hours by the AAFP.

INFO: Registration deadline, May 4, 1978; $10.00 per person. Make check out to Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

May 12-14: *Parathyroid Disorders—Contemporary Medical and Surgical Management.* Course Directors Franklin D Schwartz, MD (Medical) and Louis T Tenta, MD (Surgical). Tuition: $250.00 and $50.00 (residents and Fellows). Inquiries: Medical Education Dept, Saint Joseph Hospital, 2900 N Lake Shore Dr, Chicago, Ill 60657. 312/975-3454. p2-3/78

May 19-20: Iowa Regional Meeting of the American College of Physicians, at University Hospital (William B Bean Auditorium), Iowa City, Ia. Attendees eligible for credit toward AMA-PRA in Category I. Info: Leslie W Swanson, MD, FACP, Forest Park Medical Clinic, 1023 Second St, SW, Mason City, Iowa 50401. g3-4/78

May 19-21: *Medicine of the Whole Person,* presented by American Holistic Medicine Association and Biogenic Institutes of America (a not-for-profit foundation dedicated to health) in conjunction with and cosponsored by the American Society of Contemporary Medicine and Surgery, which certifies that this continuing medical education offering meets the criteria for 9 credit hours in Category I of the AMA Physicians Recognition Award. Contact Biogenic Institutes of America, Inc, Route 2, Welsh Coulee, LaCrosse, Wis 54601; 608/786-0611.

May 23-24: *Hematology Update 1978,* Mayo Clinic, Rochester, Minn. American College of Physicians (ACP) postgraduate course, approved by AMA Advisory Committee on CME, may be used to fulfill 19½ hours of Category I requirements for the AMA-PRA. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia, Pa 19104. g3-4/78

HEART DISEASE AND REHABILITATION—STATE OF THE ART

International conference at the
MARC PLAZA HOTEL/MILWAUKEE

May 11-12-13, 1978

Presented by Mount Sinai Medical Center (Cardiovascular Disease Section), Milwaukee, in cooperation with the University of Wisconsin-Madison, School of Medicine; the American Heart Association/Wisconsin Affiliate; University of Wisconsin-Milwaukee, and Dept of CME Health Sciences Unit-UW Extension.

A faculty of 41 men and women, representing 19 states, Canada, and Sweden will address the symposium.

Physicians, physiologists, physical educators, nurses, and therapists from across the United States and abroad will attend.

Focus will be on the epidemiology and pathophysiology of heart disease, with examination of the medical and surgical options that are available for the treatment of heart disease. The role of exercise-based rehabilitation programs in the management of heart patients also will be explored.

Program is accredited by the UW-Extension, Dept of CME, for 2.0 CEUs. Offering has been approved for 24.6 contact hours by the WNA-CEARP Committee. AMA Category I 20 credits towards AMA-PRA.

Registration deadline: April 7.

Program fee $200 for physicians and $75 for nonphysicians. Further info and for registration forms, contact the Public Relations Dept, AHA/WA, 795 North Van Buren, Milwaukee, Wis 53202; phone 414/271-9999.

1978 OTHERS

June 17-18: Fifth Annual UCLA Biofeedback Seminar: *Practical Applications of Biofeedback in the Health Sciences,* at Los Angeles Marriott Hotel, Los Angeles, Calif. Approved for 12½ hours of Category I credit toward CMA Certificate in CME and the AMA Physicians Recognition Award. Fee: $185. Info: Health Sciences, UCLA Extension, PO Box 24902, Los Angeles, CA 90024 or call 213/825-5840. g3-5/78

Sep 11-13: American Cancer Society *National Conference on the Care of the Child with Cancer,* at The Sheraton-Boston Hotel, Boston, Mass. Attendance open to all members and students of the medical, nursing, and related health professions. Advance registration requested. No registration fee. Accredited for CME. Info: Sidney L Arje, MD, ACS, 777 Third Ave, New York, NY 10017. g3-8/78

WISCONSIN PSYCHIATRIC ASSN ANNUAL SCIENTIFIC MEETING

Apr 28-29, 1978/Marshfield Clinic

Friday, Apr 28: *Medical and Psychiatric Utilization of Services*

Saturday, Apr 29: *Behavioral Change from 4 Viewpoints*

Acceptable for 10 credit hours, Category I

Info: Edwin Hoeper, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, Wisconsin 54449

CONTRIBUTIONS—CES FOUNDATION
January 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1978.

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JCAH ISSUES NEW STANDARDS FOR MEDICAL STAFFS

On February 1, 1978 the Joint Commission on Accreditation of Hospitals' *Revised Standards for Medical Staffs* went into effect. Dr John E Affeldt, the president of the Joint Commission, had the following outlook on the Standards: "We're saying to doctors, 'To ensure good patient care, these standards should be followed. They'll help you evaluate your own practices, skills, knowledge, and outcomes—and you'll do that within your own staff." The most significant changes for doctors will be:

- STAFF MEMBERSHIP—*Qualification*—Beyond requiring a medical license and formal application, the old standard set few specific requirements for staff membership and clinical privileges. Now medical staffs will have to take a harder and more detailed look at the applicant's credentials.

- STAFF MEMBERSHIP—*Delineation of Privileges*—After years of holding simply that there will be privilege delineation for medical staff members, the Commission found that this provision was getting more lip service than anything else. The new standard is meant to assure that the right staff member is doing the right things to the patient. So specialty designation such as "general surgery" or "family practice" will no longer be enough.

- STAFF MEMBERSHIP—*Reappointment*—For the first time in the Standards, a doctor's health will be one of the factors that must be weighed in considering his reappointment.

- STAFF ORGANIZATION—Every staff doctor's responsibility should be spelled out in the bylaws, whether he's a courtesy member who admits maybe 12 patients a year or an active staff member who fills half the beds on a service.

- STAFF REGULATIONS—Provisions about medical staff bylaws, rules, and regulations remain essentially the same as before, but with a "clarification" of the requirement that bylaws establish fair hearing and appeal mechanisms in connection with denial of appointment or reappointment, as well as curtailment, suspension, or revocation of privileges.

- STAFF MONITORING—A sign of the times is this new standard requiring that patient care be evaluated on a regular basis through utilization review, audits, and other mechanisms established by the medical staff. Quality controls will include not only tissue review but reviews of pharmacy and therapeutic activities, blood utilization, clinical use of antibiotics, and other patient-related professional activities.

- STAFF EDUCATION—The old continuing education requirements were brief and vague; they've been expanded and made more specific. The Standards require a hospital-sponsored program designed both for refresher work and for introducing new diagnostic and therapeutic techniques. The Standards also specify that in small, nondepartmentalized hospitals, the continuing education sessions cannot be less than quarterly, although they may be tied in with medical staff meetings.

HEALTH CARE COST ADS STILL AVAILABLE

County medical societies may still obtain reproduction proofs of the newspaper advertisements on rising health care costs which were developed by the SMS Communications Department last fall. Upon request, the Communications Department will send county medical societies proofs of the ads which are suitable for placement in their local newspapers. So far, many county medical societies have elected to place the ads in their local papers; it's not too late for yours! ■

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Socety.

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INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice." ■

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Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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1903 - 1978 75th ANNIVERSARY YEAR

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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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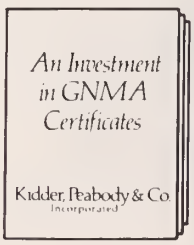
WMJ-48



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NEW STERILIZATION REGULATIONS IN EFFECT

The Wisconsin Department of Health and Social Services has announced that it will no longer cover sterilization services of persons under 21 years of age under the Wisconsin Medical Assistance Program. This change in policy is a result of Wisconsin's program conforming with the US Department of Health, Education, and Welfare's moratorium on sterilizations of people under 21 that began on July 27, 1973.

As a result of this policy change, the consent to sterilization forms (HCF-4) previously furnished to Medicaid providers are no longer appropriate since they refer to age limit of 18. DHSS asks providers to utilize the forms they now have on hand and to delete the number "18" on page two in the middle paragraph and replace it with "21". The change on the form from 18 to 21 years must be made in ink (preferably black) and must be initialed by the recipient. Forms supplied to providers afer April 1, 1978 will reflect the 21-year age limit.

MEDICAL EXAMINING BOARD RELAXES AMPHETAMINE RULE

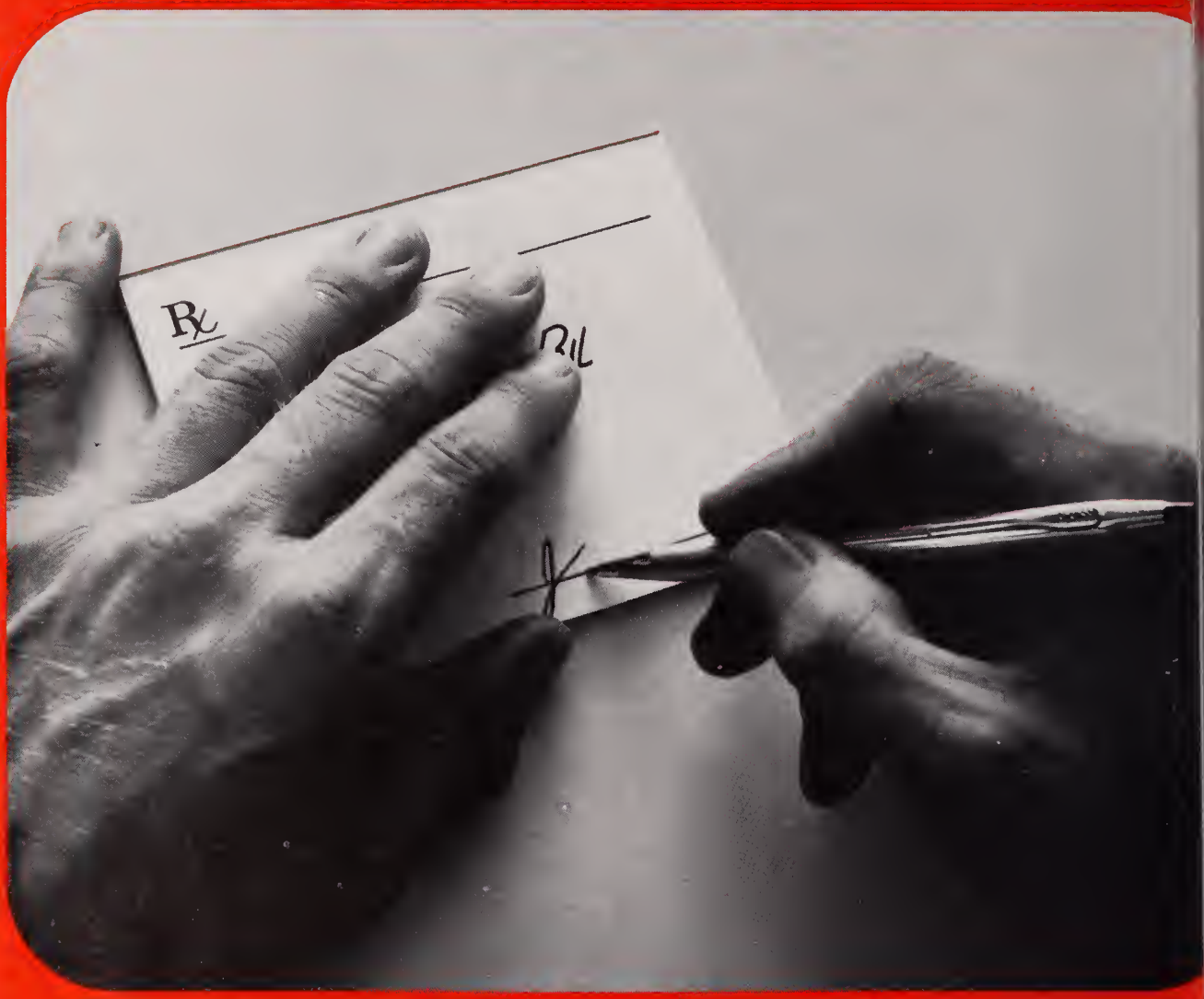
The State Medical Examining Board has proposed an amendment to its November 1, 1977 amphetamine ruling which would limit the ban to drugs in the high abuse potential (schedule II) category. This rule is *not* effective immediately. The Board projects that the effective date for the revised rule will be June 1, 1978, provided that it is approved by legislative committees. Until that time, physicians must comply with the existing ban on most schedule II, III, and IV amphetamine or sympathomimetic amine drugs or compounds. The Board will notify all Wisconsin physicians before the new rule becomes effective. The proposed amendment to Chapter Med 10.02 of the Wisconsin Administrative Code reads:

> "Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine or *sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of the Chapter 161 Wisconsin Statutes* to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or the treatment of drug induced brain dysfunction, *or for the treatment of epilepsy,* or the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the Board before such investigation has been begun."
>
> "INFORMATIONAL NOTE: The following list, although not exhaustive or exclusive, does include most of the brand-named drugs available in the United States as of March 1, 1978, which fall within the definition of this subsection: Benzedrine, Biphetamine, Delcobese, Desoxyn, Dexamyl, Dexedrine, Eskatrol, Fetamine, Obetrol, Obotan, and Preludin."

REMINDER: NEW STATE LAB BILLING PROCEDURES IN EFFECT

As of February 1, 1978 all physicians are required to identify on the final patient or third-party billing statement, the actual amount charged by the State Laboratory of Hygiene for services it performed. To date, the State Department of Health and Social Services has not sent out any instructions to physicians as to how to accomplish this task. The State Medical Society recommends that physicians list the State Lab of Hygiene charge as a separate item on the patient and third-party *final* billing statement only, *not on the patient charge slip.* This does not preclude a physician from charging a patient or carrier for such professional services as drawing blood for tests, postage to the State Lab, or handling fees. Failure to comply with this law will result in a $250 penalty. ■

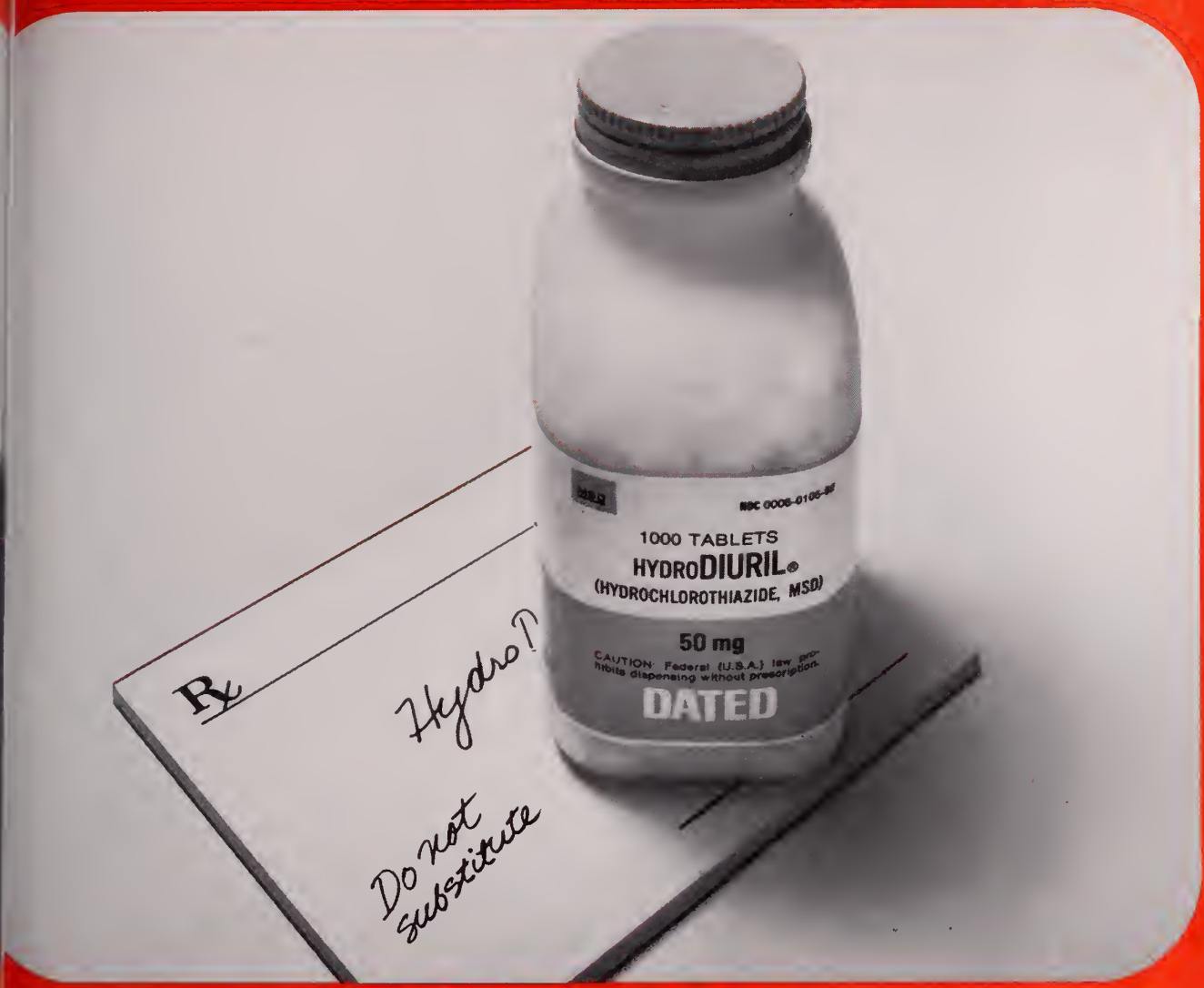
There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitali may also influence serum electrolytes. Warning signs, irrespective cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness restlessness, muscle pains or cramps, muscular fatigue, hypotensi oliguria, tachycardia, and gastrointestinal disturbances such as na and vomiting. Hypokalemia may develop, especially with brisk diur in severe cirrhosis, with concomitant corticosteroid or ACTH therap with inadequate oral electrolyte intake. Hypokalemia can sensitize exaggerate response of heart to toxic effects of digitalis (e.g., increa ventricular irritability). Hypokalemia may be avoided or treated by u of potassium supplements, such as foods with a high potassium co tent. Any chloride deficit is generally mild and usually does not requ specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instance when the hyponatremia is life threatening. In actual salt depletion, a propriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in cert patients. Insulin requirements in diabetic patients may be increase decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiv ness of the pressor agent for therapeutic use. If progressive renal in

or experience—



or ours.

rment becomes evident, consider withholding or discontinuing etic therapy. Thiazides may decrease serum PBI levels without ns of thyroid disturbance. Calcium excretion is decreased by izides. Pathologic changes in the parathyroid gland with hypercemia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

verse Reactions: *Gastrointestinal System*—Anorexia; gastric irtion; nausea; vomiting; cramping; diarrhea; constipation; jaundice rahepatic cholestatic jaundice); pancreatitis; sialadenitis.

ntral Nervous System—Dizziness; vertigo; paresthesias; headache; ithopsia.

matologic—Leukopenia; agranulocytosis; thrombocytopenia; astic anemia.

rdiovascular—Orthostatic hypotension (may be aggravated by ohol, barbiturates, or narcotics).

persensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing giitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress luding pneumonitis; anaphylactic reactions.

her—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; akness; restlessness; transient blurred vision.

nenever adverse reactions are moderate or severe, thiazide dosage ould be reduced or therapy withdrawn.

ote: When used with other antihypertensive drugs, careful observans for changes in blood pressure must be made, especially during tial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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And so we scorn the codfish,
While the humble hen we prize,
Which only goes to show you
That it pays to advertise.
—ANONYMOUS

ONE MIGHT AGREE that if the above hen were really humble and professional and ethical, she'd let her actions speak for her and leave the advertising to the purveyors of less lofty services. But our liberal press, as it guides America toward universal mediocrity under the banner of consumer protection and economy, has come out firmly in favor of physicians advertising.

Its advocates tell us there's nothing unprofessional about advertising if we follow certain guidelines in composing our ads and stay within the bounds of truth, avoiding claims of cures or publication of satisfied customer testimonials. It will, they say, permit the prospective client to do some comparison shopping, and by simply running down the ads he can order the cheapest possible cholecystectomy, satisfaction guaranteed (appendix removed at no extra charge).

For the sake of argument, let's assume physicians accept the concept. Which advertising medium should they use? Which would be in the best taste? The most efficient? The most discreet? The most economical? (After all, even the press must realize the cost of advertising will ultimately land in the lap of the consumer.)

The telephone company Yellow Pages immediately come to mind as a low-cost means of spreading the word. A tidy little box on the appropriate specialty page listing training, honors achieved, office hours, hospital affiliations and fee schedules woul reach a wide audience and would not be wasted on th "well" as newpapers and television advertising woul be.

But the same sort of ad could be used in the news papers; and appropriately targeted, would be quite ef fective. For example, gynecologists could use th Women's Section, of course, and urologists the Sport Page or Finance Section.

One problem with newspapers, radio, and tele vision, though, is the very broadness of their targe areas, with resultant tendencies for overkill. Their ad are expensive, too, simply because they do reach s widespread an audience, and yet the average specialis in Madison, for instance, would stand little chance o cracking the Milwaukee market since Milwaukee spe cialists would be beaming back equally enticing ads o their own.

Radio and television do offer advantages which might offset their higher cost in certain selected situations, however. Think how effective a brief commercial extolling the skills of an enterprising gastroenterologist might be if it were slotted during a thirty-second break in the six o'clock news just as you're beginning to regret that Mexican dinner or just as you're turning off Johnny Carson at that moment when the gallbladder begins to make its presence known. Perhaps the gastroenterologist could even share the spot with a surgeon to their mutual benefit and with even greater economy.

With renewed interest in mass transit, those placards placed above the windows on buses should make a comeback. They might provide just the right exposure for the budget-conscious medical entrepreneur:

"A dragging bosom can be nasty—
Why not try our mammoplasty"
Phone 123-4567

or:

"Proctologic work in order?
Back right up to Dr Hoarder!"
Phone 765-4321

Possibilities are endless.

If this sort of thing amuses you, fine; but if you think about it, it ought to arouse your concern. If we allow this sort of practice to take hold, it can only work to the detriment of the patient, because the real professional won't participate. The charlatans and fringe operators will have a field day preying on the gullible. Then there really will be unnecessary surgery, an increase in quackery, and even more money spent on "health" care. Unspectacular as she is, let's get behind the codfish! —WJB

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In Editoriols, the views expressed, if initioled or signed, ore those of the writer ond not necessorily officiol positions of the Society.

Slow suicide

RECENTLY I WITNESSED two autopsies. Both patients had died miserable deaths, both had bronchogenic carcinoma and both had pulmonary emphysema. Both had been heavy cigarette smokers and both continued to smoke up until the day they died and both had burned holes in the hospital bedding.

Judging by the improvement in the environment at medical meetings it appears that many doctors have gotten the message equating cigarette smoking with lung cancer. In past years it was virtually impossible to view the proscenium through the pall of blue cigarette smoke. Now one sees only an isolated column of smoke emanating from some unreconstructed physician.

Why is it that the dire prospects of fatal and premature pulmonary disease don't seem to carry as much weight with adolescents as does a lanky tatooed cowhand? What happened to the old restrictions on smoking in or around schools and training regulations for high school athletes? A renewed education campaign with active physician participation is certainly indicated. And it's much more convincing if the physician is a non-smoker!—VSF

Medical records resources

IN THIS ISSUE on page 18 is an article entitled "How to Get Health Related Information in Wisconsin." This was prepared at the request of the Journal editor by Virginia Holtz, head of the William S Middleton Health Sciences Library at the University of Wisconsin, Madison.

This details the resources available to Wisconsin physicians requiring in-depth information on any medical subject. It should be especially helpful for anyone preparing scientific papers or lectures or simply desiring more information than might be available at the local level. —VSF

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GUEST EDITORIAL

Premedical apprenticeship as a selective tool for medical school admission

THE GROWING DISSATISFACTION with academic grades as the main selective criterion for admission to the study of medicine is an undeniable fact. Letters of recommendation and personal interviews as supplementary selective tools are fine but are difficult to evaluate. Connections and showmanship are hard to avoid in the process.

Since medicine is as much a matter of social skill and an art as it is a science, it would probably not be unreasonable to combine the time honored principle of an apprenticeship with our modern methods of quantitative test evaluations. This would give back a dimension to our medical student body which has been almost lost during the past half century, much to the dismay of our patients. In past centuries, apprenticeship was the mainstay of selection. With the rapid expansion of our knowledge, the so-called quantitative objective academic assessment methods simply

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crowded out the apprenticeship idea from the curriculum. It appears that the time has come to revive it as a selective tool. This would bring back into our medical profession important human qualities for which our society is increasingly crying out. What else but a covert expression of protest, for example, is the whole ugly business of malpractice and liability litigation?

The idea is to introduce a practical year of apprenticeship after high school graduation and before admission into the first premedical college year. After successful completion, it would then count as the first of the usual four premedical years. The advantages of such a change would be numerous:

1. There would be a great deal of information on the human qualities of an applicant which could form a counterweight against the "Tyranny of Testing" as Banesh Hoffmann has called it.

2. Students of a less affluent background and minorities who had no opportunity to attend a college prep school would have a better chance to show their qualities.

3. Since these premedical apprentices would have to be paid, disadvantaged students would get some financial relief during their first year.

4. Many apprentices may get interested in one of the countless paramedical careers with which they come in contact in a hospital. It is conceivable that this would steer a good number of students into these rapidly growing and very important areas of health services.

5. Apprentices who are not really comfortable with demanding, sick, helpless and dying people would be able to change their professional goals without losing face, before they have invested an inordinate amount of time, effort, and money and could not turn back any longer.

6. A full year of apprenticeship will certainly, better than any other method, reveal the real human substance of which the future medical student is made. This would help greatly in selecting the best people for our medical schools and not just the ones who have the greatest skill of making good grades in written tests.

7. Stipends and grants after a year of observation of a student at work can be channelled much better to those who would make the best use of them.

The apprenticeship system has made our Western Civilization what it is. I would call it humanism at work. It has helped us to preserve the humanitarian ideals of our profession throughout nearly three millennia. To replace it now with computers is bound to fail. Even the brave new world of medicine cannot be put into figures. Let us place the human experience of the apprenticeship where it belongs: at the beginning of a career devoted to human needs.—KURT A HOEHNE, MD, Winnebago

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A fantastic colonial on North River Road on a superb wooded lot featuring a small lake with sand swimming beach, large swimming pool, guest house, masonry cooking grill and patio, and a large three car garage building. The house is absolutely immaculate—you must see it to believe it. The first floor features a large oak-paneled foyer, a lovely living room with fireplace, gorgeous paneled den, charming formal dining room, fabulous family room with fireplace, wonderful kitchen with breakfast room and fireplace, utility room, garden room, screened porch, large master bedroom (with walk-in closet) and bath, and two guest lavatories. Five bedrooms, three baths and a sewing room upstairs. Additionally, a finished basement with wet bar, arts and crafts rooms, game rooms, lavatory; central air; elevator; four car heated attached garage—and more. Everything in perfect condition.

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SPECIAL TO THE JOURNAL

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee (Medical College of Wisconsin Medical Library). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Midwest Health Science Library Network, which encompasses a six-state area, to the National Library of Medicine; and, if necessary, to the British Lending Library.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computerized MEDLINE searches can now be done at the resource libraries and at the Luther Hospital, Eau Claire; LaCrosse Lutheran Hospital; the Howard Young Medical Center, Woodruff; and St Mary's Hospital in Madison. If your local library cannot provide MEDLINE, it can forward any request to the most appropriate library in the network.

In most cases, the only charge will be for MEDLINE searches (generally $4.00) and for photocopies.

Medical Library Service
University of Wisconsin
Middleton Health Sciences
Library
1305 Linden Drive
Madison, Wisconsin 53706

Medical College of Wisconsin
Medical Library
560 North 16th Street
Milwaukee, Wisconsin 53233

■

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

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PREPARED AND SUPPORTED BY

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STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

Cancer epidemiology

In the past five years there has been a marked increase in public interest in cancer epidemiology. Almost daily there is some report in the lay press that a new dietary or environmental factor has been implicated as a cause of cancer. Unfortunately many of these reports have been anecdotal, and on closer scientific examination, they have proved to be unfounded. As a result of these reports, the practicing physician is often confronted with questions from his patients about the possible dangers of eating certain foods, exposure to certain chemicals, or the carcinogenic properties of various medications.

Since few physicians have the time to read and analyze all the reports that appear in the lay press, we will try to provide the practitioner with a foundation in cancer epidemiology in a series of articles. The most important demographic and epidemiological factors that have been associated with the more common cancers important to Wisconsin citizens will be discussed.

Endometrial cancer

The worldwide incidence of endometrial cancer in high-risk countries such as Japan, Austria, and Chile is three times that of lower risk countries such as Norway, New Zealand, and Australia. In the United States the incidence is greater in the north than in the south,[1] but no Wisconsin county has a mortality rate significantly higher than the national average. White women also have a greater risk than black women.

The incidence increases with age up to age 60 years, then decreases. As with breast cancer, nulliparity and late menopause have been associated with an increased risk. Associations also have been reported with hypertension, diabetes mellitus, obesity, increased height infertility, dysfunctional bleeding, adenomatous hyperplasia, Stein-Leventhal syndrome, thyroid disease, breast cancer, ovarian cancer, and colorectal cancer.[2,3] Diets high in fat may be a factor also. Women who take exogenous estrogens have a risk 2-2½ times normal,[4] which apparently increases with the duration of the exposure. (To be continued)

—Jane Harberg,
Richard Friedman, MD
Dorothy J Buchanan-Davidson, PhD

References

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2. MacMahon B: *Gyn Oncology* 2:122-129 (1974)
3. Kessler II: *J Chron Dis* 23:579-600 (1971).
4. Hoogerland DL; Buchler D; and Crowley J: *Int J Gyn Onc* to be published.

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Supported by NCI Grant No. 5 R18-CA-16405-03.

ECOG—A university without walls

Cooperative groups are like a university without walls dedicated to excellence in research, patient care, and education. They have come into being since World War II to outline clinical testing procedures for drugs which have anti-cancer activity.

One of the largest of these groups is the Eastern Cooperative Oncology Group (ECOG) which was formed in 1956. The group has expanded from a five-member east coast alliance of mainly chemotherapy oriented physicians to an international group of over 183 medical schools and hospitals and 961 investigators who represent all specialties of medicine, trainees, nurse oncologists, and biostatisticians. Members come from the United States, Canada, Australia, South Africa, Italy, and Germany. Approximately 8,000 patients are being followed and about 3,500 new patients were enrolled into over 40 ECOG studies in 1977. Dr Paul Carbone, associate director of the Wisconsin Clinical Cancer Center, is chairman of the group which now has its headquarters in Madison.

In cooperative group activity there has been a marked shift of emphasis from chemotherapy to multimodal treatments. About 45% of all patients entered in 1977 were enrolled in multimodality studies involving chemotherapy, surgery, radiotherapy, and/or immunotherapy.

The major scientific program of ECOG is the responsibility of disease and modality-oriented committees. Protocols are developed by the disease steering committees with input from each of the appropriate modality committees and biostatisticians. The present committees are breast, gastrointestinal, head and neck, hematology (lymphoma and myeloma, lung, melanoma, genitourinary—gynecology, immunology, pathology, radiotherapy, surgery, cancer control, and new agents.

The clinical trial is basically a well designed plan to evaluate the effectiveness of one approach versus another, its safety and tolerance, and the immediate as well as long-term benefits. Current strategy in cancer treatment requires the integration of optimal surgery and/or radiotherapy as well as systemic chemotherapy which may include hormones and immunostimulation agents. The complexity of treatment options is multiplied many fold because not only can the kinds of operations and the dose and rate of radiotherapy be varied, but also the kind and number of drugs. The time sequence of application of these various treatments can also be changed to improve the treatment outcome.

Plans are presently being made to include a more complete and thorough evaluation of histopathological material in the clinical trials. It is hoped that future trials can be designed to provide not only better treatment but also a better understanding of tumor biology. And as new types of therapy become available, they will be tested and integrated into the treatment programs.

Besides the clinical research aspects of cooperative group studies, ECOG

has developed an effective cancer control activity that brings community physicians and nurse oncologists in for informational and educational activities. Regional control activities have included visiting oncologist programs and tumor boards. At the group meetings there are educational workshops on such issues as the psychosocial aspects of cancer, role of nurse oncologists, and legal and ethical issues in clinical trials.

The ECOG meeting this year will be held June 1, 2, and 3 at the Concourse Hotel in Madison, Wisconsin. The cancer control workshops will be on "What Cooperative Groups Can Do in Educating Professionals Interested in Cancer," June 1 from 9-12 AM and on "Nutrition in Cancer" on June 3 from 8:45-11 AM. These two sessions are free.

If you are interested in attending the committee meetings June 1 and 2, to learn more about clinical trials and ECOG, you can obtain more information from Dr Paul Tracy (608) 263-3455 or David C Reynolds (608) 263-6947 at the Wisconsin Clinical Cancer Center. There is a registration fee of $10.00 which includes a luncheon and two receptions. The deadline for registration is May 15.

—DOROTHY J BUCHANAN-DAVIDSON, PHD
Science Writer
Wisconsin Clinical Cancer Center

See the Yellow Pages section for information about the Spring Cancer Conference to be held in Fontana, May 18. ■

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS APRIL 1978

Annual Meeting

THE WISCONSIN SOCIETY of the American Association of Medical Assistants will hold its Annual Meeting on May 19, 20, 21, 1978 at the Ramada Sands, Bluemound Road, Wauwatosa, Wisconsin. Waukesha Chapter will be hostesses for this event. The theme for this meeting will be "BLOOM WHERE YOU ARE PLANTED." We hope to inspire the members to do the best they can wherever they work or live.

On Friday, May 19, the preconvention Executive Board meeting will be followed by a luncheon for the Delegates. The House of Delegates will convene on Friday afternoon to conduct the business of the Society. Election of new officers and updating of the State Constitution will be done at this meeting.

Saturday, May 20, will be devoted to education, following a formal welcome to the group by President Dolores Conlon and the Mayor of Waukesha. The two-hour morning session will be devoted to "Death and Dying." We hope Elizabeth Kubler Ross will be present to speak on this subject. However, if she is unavailable, her talk will be presented by Father Michael Stolpmann. The first afternoon presentation will be on "Medical Terminology" by Mary Carven Byrne, RN. Following this presentation Mr Melvin Schultz of Professional Management of Milwaukee, Inc will speak on "Office Collection Procedures. CEUs (Continuing Education Units) will be given to all participating members who pass the examinations following each presentation.

On Saturday night the formal banquet will be held with installation of officers for 1978-79. At this time President Dolores Conlon of Milwaukee will relinquish the gavel to incoming President Jane Dowds, CMA-AC of Janesville. Mrs Dowd's county chapter will honor her with a President's Reception immediately following the banquet.

On Sunday morning, May 21, an Ecumenical Church Service will be conducted by the Rev Dean Marek of Waukesha. Following this a brunch will be served. At this time the Summary of the House of Delegates Meeting will be reported to the members and the new president will announce her committees. An invitation to attend the 1979 convention in Eau Claire will be issued by the Eau Claire Chapter. Following announcements, the meeting will close and the members will go their various ways to "BLOOM WHERE THEY ARE PLANTED."

—MARIAN LANGE and PEGGY GALLAGHER, CMA
Co-chairmen Annual Meeting ■

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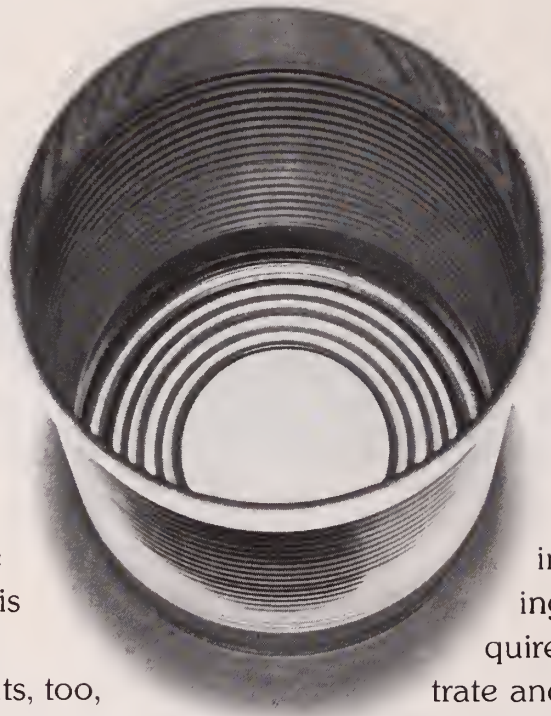

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State Health Plan aired at public hearings

A draft of the state's major health policy document—State Health Plan—was released in March for review and comment prior to public hearings slated during April (see MEDIGRAM, March 21 issue).

Comments will be taken into account by the Health Policy Council when it votes on the final form of the Plan at its June 22-23 meeting in Madison.

The Plan, which is required under federal and state planning legislation, will be revised annually.

The State Medical Society has appealed to the Health Policy Council and the State Department of Health and Social Services to establish small, technical advisory committees on each section of the more than 700-page document to review and rewrite to correct glaring errors and improve the basic integrity of the document as a planning instrument. ■

MDs and SMS Staff learn the "art" of negotiation

SMS physicians and Physicians Alliance staff had an opportunity to participate in a Negotiations Seminar at the Pioneer Inn in Oshkosh, March 18-19.

Hailed as a success by those individuals participating, the seminar was lead by two staff members of the AMA Department of Negotiations with lectures on basic negotiating skills. Participants then were divided into "teams" for mock negotiation sessions to test those skills.

At seminar's end, all participants should have gained a better understanding of how to effectively cope with others whether they be patients, hospital management personnel, health systems agencies, insurers, or other third-parties in order to both preserve the physician-patient relationship and to improve the quality of patient care.

The following physicians participated in the seminar: MDs Kenneth M Viste Jr, Oshkosh; Michael P Mehr, Marshfield; Charles N Ford Jr, LaCrosse; Joseph M Lubitz, Oconomowoc; Richard Biek, Milwaukee; Russell Quirk, Racine; Jordon Frank, Beloit; Joseph Diraimondo, Manitowoc; Carl Eisenberg, Milwaukee; Raymond C Zastrow, Wauwatosa; and Paul S Haskins, River Falls. ■

SMS urges Governor to sign professional liability bills

Two important bills concerning professional liability now await Acting Governor Martin Schreiber's signature. Assembly Bill 705, recently passed by both houses of the Legislature, will shorten the statute of limitations for minors in medical malpractice actions to three years or age 10, whichever is later.

The passage of AB 705 with the age 10 limit represents a major victory for the State Medical Society which strongly supported the measure.

The Senate and Assembly also have passed Assembly Bill 237 which would allow a defendent in a lawsuit to move for dismissal of the suit on the grounds that it is without any basis in law or equity, or that the suit is designed primarily to harasss the defendent. (*Late news:* The Governor on March 29 signed into law AB 237 (Chapter 209, Laws of 1977.)

SMS is urging the Governor to sign both of these major professional liability bills. ■

SMS continues its opposition to health planning guidelines

"The Department is doing the public a disservice," said the State Medical Society, "in considering standards that give the appearance of having local flexibility when in reality all that has been accomplished is to change the agency accountable to the Department of Health, Education, and Welfare."

In a statement opposing the revised Federal Guidelines for Health Planning, the Society said the present draft represents a "modest improvement" over the September 1977 version. In particular, the Society said the requirement of an 80% occupancy rate in all non-federal hospitals, coupled with four non-federal short-stay hospital beds per 1,000 persons is unrealistic.

"We are very concerned that this planning document will become a yardstick for decertification or appropriateness review in this area."

Copies of the Society's comments to HEW may be obtained by contacting SMS headquarters in Madison (phone toll-free: 1-800-362-9080). ■

Britain travel opportunity available

All SMS members and auxiliary have an opportunity to travel to Britain next fall.

Each SMS member was mailed a flyer outlining details of the trip scheduled for September 20-28, 1978.

Participating individuals will choose between two travel programs: one offers independence for those who want to sightsee by themselves; and another, guided tour.

Inquiries may be made to the SMS headquarters in Madison (phone toll-free: 1-800-362-9080). ■

MD input sought on C-O-N rules

The State Medical Society has protested the cardiac catheterization and open heart surgery administrative rules which were proposed as part of the certificate-of-need (C-O-N) law, effective July 1, 1977.

That protest was based on a commitment SMS had received from the State Department of Health and Social Services (DHSS) to have technical advisory committees meet to discuss and review all new C-O-N rules. The DHSS did not follow this process in developing the rules. The DHSS now has indicated that it will be creating technical advisory committees to review the rules in the next 30 days, and it is seeking input from all affected parties.

Physicians with suggestions or comments on the proposed cardiac catheterization and open heart surgery C-O-N rules should contact SMS headquarters in Madison (phone toll-free: 1-800-362-9080). ■

Optometry bill gets legislative approval

The State Senate and Assembly have passed Assembly Bill 281, the optometric drug bill, as it was amended in the Senate. AB 281, as amended, imposes major restrictions and requirements on optometrists who wish to use drugs in their practices. The original bill would have permitted optometrists to use drugs for diagnostic purposes if they had successfully completed a course in pharmacology.

AB 281, which now awaits Acting Governor Martin Schreiber's decision, was the subject of intense debate over the past year between the State Medical Society and the Wisconsin Optometric Association.

SMS was successful in securing the adoption of many amendments to the original bill including a "mandatory referral" amendment which the optometrists strongly opposed.

Among the new requirements now contained in the bill:

- Only *topical* drugs can be used by optometrists.
- The practice of optometry does not include surgery, medical treatment, or the use of therapeutic drugs.
- All optometrists who use topical drugs must complete 30 classroom hours of study in clinical pharmacology, and successfully complete an examination in pharmacology and treatment of adverse reactions.
- All optometrists using topical drugs must establish an approved plan of referral of patients suffering adverse reactions to appropriate medical care.
- All optometrists are required to refer patients to an appropriate medical specialist if it is determined that the possibility of a pathological condition exists.
- All optometrists using topical drugs must report all problems with the use of drugs to the Secretary of the Department of Regulation and Licensing.
- The Secretary of the Department of Regulation and Licensing shall report to the Legislature by January 1, 1982 on the use of topical drugs by optometrists detailing whether or not patients have suffered physical or psychological harm as a result of optometrists' use of drugs. ■

Annual Meeting highlights to appear in May issue

A Summary Report of the SMS House of Delegates actions at the April 13-15 annual session will appear in the May issue of WMJ. ■

Legislature asked to tighten tax record access

The State Medical Society is strongly urging the Legislature to adopt a provision in the Budget Review Bill (AB 1220) that will tighten up the access to personal income tax records in Wisconsin.

The provision, as drafted by the Department of Revenue, would authorize only one legislative committee to grant access to tax records, rather than all legislative committees as is currently the case.

This action follows public disclosure that a University of Wisconsin-Madison student had been given authority by a State Senate Committee to examine nearly 3,000 physician income tax returns. ■

Two promoted and two added to SMS staff

SMS promoted two and welcomed two new staff persons in March, and accepted one resignation.

The State Medical Society has named Brian H Jensen director of the Physicians Alliance Division. He succeeds Paul Simms who resigned in February.

Jensen, who had been acting director since February, and the SMS-PA field consultants will work toward increasing activity in the economic and advocacy role of the Physicians Alliance as well as strengthening its existing legislative-political framework.

The 27-year-old Jensen joined the SMS staff in May 1976 as a legislative coordinator for the Physicians Alliance Division.

Douglas E Nelson has been named director of the SMS Quality Care Division. In his new capacity Nelson will direct the programs involving peer review, continuing medical education, health planning, mediation and professional ethics, and community health services.

The 30-year-old came to SMS three years ago as a field consultant, and for the past two years has been the legislative coordinator for the Physicians Alliance Division.

Miss Marge May, who for many years filled supervisory and coordinator positions in the WPS claims department, has rejoined the SMS staff in the Physicians Alliance Division. She will act in a liaison capacity with third-party carriers, most particularly in the Title 19 medical assistance policy area, and with the Physicians Alliance field consultants.

Peter Wood, a native of England, fills a new position in the SMS Member Benefits and Services Department. Wood will be working on increasing the number and quality of membership benefits and services. Wood previously was a financial consultant in Kansas City.

Bill Wendle, who has been coordinator of continuing medical education, has resigned effective May 6 to accept a position in health planning with the Wisconsin Hospital Association. Wendle joined the Society in 1974 with his initial assignment to the health resources committee. In the succeeding four years Wendle has directed the Annual Meetings and coordinated the continuing medical education program. He has represented the SMS in health planning activities and served on committees charged with setting standards and guidelines for quality assurance in the delivery of medical care. ■

Justice Department initiates "inquiry" of medical societies

SMS legal counsel has had a preliminary discussion with the State Department of Justice in relation to the Department's inquiry of the SMS and each component county society about possible antitrust violations.

It is clear that the Department's interest is in any involvement of societies in the use of relative value schedules and conversion units.

The Wisconsin action follows a national trend in which medical societies in other states also have received similar "inquiry" notices.

Further discussions of the Wisconsin inquiry will be held, and as soon as the Society legal counsel has advice or information for county societies, it will be communicated (see *NewsClips* in MEDIGRAM, March 21 issue). ■

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Nursing home licensure rules to be reviewed; SMS involved

The State Division of Health wil be reviewing the administrative rule for nursing home licensure in Wis consin. SMS and the three nursing home associations in the state will b assisting in the review process.

Physicians with suggestions for im provements in the rules should direc their comments to SMS headquarter in Madison (phone toll-free: 1-800 362-9080).

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report
as of March 6, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

LACROSSE

Lathrop, Thomas P, 1836 South Ave, LaCrosse 54601 (1943, Regular, Internal Medicine, Certified)

RACINE

Brown, Richard J C, 840 Lake Ave, Racine 53403 (1933, Regular, Plastic Surgery/Neurological Surgery, Certified-PS)

Wright, Lewis E, 2405 Northwestern Ave, Racine 53404 (1944, Regular, Internal Medicine/Gastroenterology, Certified-IM)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BARRON-WASHBURN-BURNETT

Dunne, Morgan G, Star Prairie, to Dept of Radiology, Beckley Hospital, Beckley, WV 25801

BROWN

Troup, Ralph L, Green Bay, to 1306 Fox River Dr, De Pere 54115

DANE

Ledbetter, Marion K, Madison, to 411 Lincoln St, Neenah 54956

Meschievitz, Carlton, Ashland, to 12 Hailey Rd, New Delhi 1 India

Straughn, Robert A, Madison, to 263 Emporia No 5, San Antonio, TX 78209

Suarez, Louis A, Chicago, IL, to 2913 Patty Lane, Middleton 53562

EAU CLAIRE-DUNN-PEPIN

Thomson, Douglas E, Eau Claire, to 1140 West Park Ave, Chippewa Falls 54729

LACROSSE

Shields, John C, LaCrosse, to Post Office Box 351, Lancaster 53818

MILWAUKEE

Lee, Paul A, Milwaukee, to 131 Spring Street, Santa Cruz, CA 95060

Stanhope, C Robert, Glenview, IL, to 5168 Forest Way, Bloomfield Hills, MI 48013

WINNEBAGO

Conway, John E, Neenah, to 1203 Nicolet Circle, Appleton 54911

WOOD

Young, John R, Marshfield, to 808 South Fourth St, Gadsden, AL 35901

COUNTY-TO-COUNTY TRANSFERS

Dane to Oneida-Vilas: Pederson, John F, Rte 3, Box 299, Minocqua 54548

LaCrosse to Oneida-Vilas: Jaeger, John G, 56 South Brown St, Rhinelander 54501

Milwaukee to Ozaukee: Conrad, Arthur B, 2403 North Harding, Wauwatosa 53226

Trempealeau-Jackson-Buffalo to Eau Claire-Dunn-Pepin: Bollinger, John T, 1428 Cummings Ave, Eau Claire 54701

DEATHS

Heinan, Frederick C, Milwaukee County, Feb 6, 1978

Mueller, Gilbert F, Milwaukee County, Feb 18, 1978 ■

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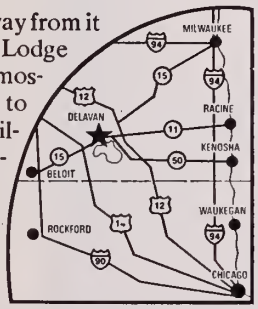

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OBITUARIES

◈County, State, AMA Members

Robert George Eising, MD, 29, died Sept 5, 1977 in Madison. Born Aug 3, 1948 in Watertown, Doctor Eising graduated from the University of Wisconsin Medical School, Madison, in 1974. An anesthesiologist, Doctor Eising took his postgraduate work at University Hospitals, Madison.

◈ **John Huston, MD,** 80, retired Milwaukee physician, died January 18, 1978 in Cedar Rapids, Ia. Born Sept 5, 1897 in Richland Center, he graduated from Harvard Medical School in 1923. Doctor Huston served in the United States Army during World War I. He practiced in Milwaukee until his retirement in 1973 and at one time was chairman of the Department of Internal Medicine at Milwaukee Lutheran Hospital. Surviving are his widow, Wanda; three sons, Dr Erwin, Milwaukee, Dr John, Cedar Rapids, Ia, and David of Maryland.

◈ **Oliver W Pfeiffer, MD,** 79, Racine, died Feb 1, 1978 in Racine. Born Dec 5, 1898 in Sheboygan Falls, Doctor Pfeiffer graduated from Marquette University School of Medicine in 1924. He served in the United States Army during World War I. Doctor Pfeiffer practiced general medicine and surgery in Racine from 1924 - 1953 until he moved to Woodruff and became secretary-treasurer of Lakeland Memorial Hospital of which he was one of the founders. In 1964, because of ill health, he moved back to the Milwaukee area and worked with the regional office of the Veterans Administration and also worked as medical supervisor on a mobile unit of the Milwaukee Blood Center. He retired in 1972. Surviving are his widow, Frankie, and a daughter, Mrs Ted (Gretchen) Erspamer, Hurley.

◈ **Fordyce A Ross, MD,** 67, Wauwatosa, died Feb 2, 1978 in Milwaukee. Born Jan 20, 1911 in Granton, Wisconsin, Doctor Ross graduated from Marquette University School of Medicine in 1936. He served in the United States Navy during World War II. Doctor Ross, a former president of the State Board of Medical Examiners, retired from medical practice in 1976. Surviving are his widow, Barbara; two daughters, Hillary, New York, and Mrs Robert C (Pamela) Mahnke of Shorewood; and a son, Geoffrey of Los Angeles.

◈ **Theodore A Heller, MD,** 69, Greendale, died Feb 7, 1978 in Milwaukee. Born Apr 22, 1908 in Milwaukee, Doctor Heller graduated from the University of Wisconsin Medical School, Madison, in 1935. He served in the United States Air Force during World War II. Doctor Heller was health commissioner for Greenfield and Hales Corners, and was on the medical staff of St Francis and St Luke's hospitals in Milwaukee. Surviving are his widow, Helen; three daughters, Patricia, Milwaukee; Barbara, Madison; and Mary, LaCrosse; and two sons, Robert, Milwaukee, and Tom of Eau Claire.

◈ **John W Maxwell Jr, MD,** 47, Milwaukee, died Feb 13, 1978 in Milwaukee. Born Nov 7, 1930 in Nashville, Tenn, Doctor Maxwell graduated from Meharry Medical College in 1954. Doctor Maxwell was on the medical staff of St Mary's, Deaconess, and St Anthony's hospitals in Milwaukee. He was a past president of the Milwaukee Urban League. Surviving is his stepmother, Mrs Hazel Maxwell. ■

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NEWS HIGHLIGHTS

DePaul Rehabilitation Hospital

. . . recently was awarded federal and state funding to provide outpatient drug treatment services for people without private funds or insurance to cover treatment costs.

The service contract, awarded by the National Institute on Drug Abuse (NIDA), will provide public funding for DePaul to maintain an outpatient program with a 20-patient capacity. This funding will augment DePaul's present drug treatment capability by providing services to those who need financial assistance.

Although DePaul has placed its primary emphasis on the treatment of people addicted to the drug, alcohol, the new contract will allow an expansion of services to those people needing financial assistance where the primary diagnosis is drug addiction—with or without alcohol.

Clinical Science Center

. . . (CSC), a most ambitious public building project in Wisconsin's history, is coming to fruition with the moving in of two components—the School of Nursing and the Wisconsin Clinical Cancer Center. Other health science departments will join them over the next two years in a phased plan capped by the move of University Hospitals in 1979. The CSC will then house the hospital and its clinics, the nursing school, the WCCC, and the clinical departments of the UW Medical School.

Begun in 1973, the cost of the Clinical Science Center has been estimated at $100 million. It is aimed at improving both the educational and clinical care aspects of the health professions taught and administered at UW-Madison. It also was designed to counter a chronic hazard of medical buildings: being out of date too soon after the doors open. Designers say the building offers flexibility for changes in space and programs, and that it can be maintained and serviced with minimum disruption of ongoing activities.

The first occupant of the towering structure located near the VA Hospital was the School of Nursing, which moved last November from its borrowed classroom spaces and a cramped 1926 building that once was a nurses' dormitory. Nursing Dean Valencia N Prock said the school now has double its previous space, individual faculty offices, modern teaching quarters, research labs it never had before, and a chance for an expanded graduate program.

The Wisconsin Clinical Cancer Center in March began moving into a seven-floor tower in the CSC, totalling about 70,000 square feet. Four floors are devoted to laboratory research. Since the WCCC's beginning in 1972, its cancer researchers have worked in labs and offices scattered around campus, WCCC director Dr Harold Rusch said.

The new building centralizes both the nursing school and the cancer center's operations.

St Joseph's Hospital

. . . Marshfield, recently announced that a 30-bed Oncology Unit had been established in the former Selective Care area of the hospital's fifth floor.

"This unit is planned, equipped, and staffed to provide individualized, quality nursing care to patients who are admitted with a known or potential diagnosis of cancer," stated Sr Sharee Hurtgen, hospital vice president-nursing.

Reidun Daeffler, RN, Oncology Clinical Nurse Specialist, joined the hospital staff in January. She is responsible for the overall delivery of quality care to oncology patients.

A native of Norway, where she attended nursing schools and Oslo University, Mrs Daeffler came to this country in 1971. She was clinical supervisor at the University of Texas Cancer Center and M D Anderson Tumor Institute before coming to St Joseph's.

A health fair

. . . for the Racine-Kenosha community was held at UW-Parkside in March. Representatives of 38 health-related agencies offered free tests and information about health testing in general. ■

PHYSICIAN BRIEFS

Paul A Capelli, MD*

. . . Kenosha, recently was appointed to the Medical Education Review Committee. His term will expire July 1, 1980. Doctor Capelli is chief-of-staff at St Catherine's Hospital in Kenosha.

James S Ziolkowski, MD

. . . Wauwatosa, recently was elected chief-of-staff of Lutheran Hospital. Roger A Goetz, MD,* Glendale, was elected vice chief-of-staff and David J La Fond, MD,* Elm Grove, was reappointed secretary. MDs elected to member-at-large positions on the medical staff's executive committee are Conrad M Heinzelmann,* Brookfield, William J Pier* and Donald A Spring* of Milwaukee.

Warren B Rudy, MD

. . . Wausau, was elected president of the Human Services Board of Langlade, Lincoln, and Marathon counties. Doctor Rudy chairs the board's personnel committee and is a member of the mental health, alcohol, and drug abuse disabilities committee.

Frederick I Bush, MD*

. . . West Bend general practitioner and surgeon, recently accepted the full-time medical director position for the Samaritan Home in West Bend. He also will serve as advisor to the Board of Trustees and Samaritan Home Administration as well as the Utilization Review Committee. Doctor Bush is past chief-of-staff of St Joseph's Community Hospital and will succeed James W Pick, MD of Milwaukee, who has served as the In-House physician on a part-time basis.

Benn Haynes, MD*

. . . Rhinelander urologist associated with the W S Bump Clinic, recently was certified by the American Board of Urology. A 1966 graduate from the University of Tennessee Medical School, he completed his internship and residency in general surgery at the University of Tennessee Memorial Hospital and Research Center in Knoxville. Following duty as a surgeon with the United States Army, Doctor Haynes completed four years of urological residency at the University of Iowa. He joined the Bump Clinic in 1976.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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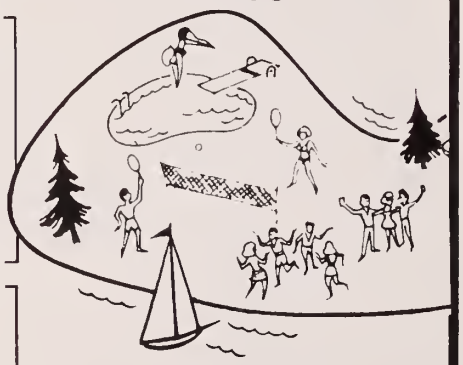

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George T Anast, MD

. . . Woodruff, recently was appointed medical consultant to the Emergency Medical Services (EMS) Systems Development Section, Wisconsin Division of Health. Doctor Anast is the state's first EMS medical consultant. He is chief of orthopedic surgery, physical medicine and rehabilitation at Howard Young Medical Center in Woodruff.

Douglas H McNeill, MD

. . . Waukesha, recently announced his resignation as associate director of the Waukesha Family Practice Program of the University of Wisconsin Department of Family Medicine and Practice. Doctor McNeill graduated from Columbia University College of Physicians and Surgeons and served a three-year family practice residency at the University of Wisconsin in Madison. He plans to open a medical practice in Poynette after Sept 1.

Anatolio G Wasserman, MD

. . . recently became affiliated with the Orthopedic Surgery Section of the Marshfield Clinic's Department of Surgery. He comes to Marshfield from Chicago where he completed a fellowship in spinal deformities at Rush-Presbyterian St Luke's Hospital. A native of Mexico City, Doctor Wasserman received his undergraduate and MD degrees there before serving internship and residency at Charity Hospital/Tulane University, New Orleans.

Rocco Latorraca, MD*

. . . Wauwatosa, recently was reelected chief-of-staff of Trinity Memorial Hospital. He is the hospital's medical director of Laboratory Medicine. MDs Vito Vitulli,* and Harold Jacobsohn,* both of Cudahy, were reelected and elected vice-president and secretary-treasurer, respectively.

David J Noll, MD*

. . . Madison, recently was reelected chief-of-staff of St Mary's Hospital Medical Center. Other MDs elected as officers are Stephen Dudiak,* chief-elect; Earl B Greenberg,* secretary-treasurer; and Robert F Korbitz,* representative to the Dane County Medical Society. All the physicians are from Madison.

Joseph J Mazza, MD*

. . . Marshfield, has been named program chairman for the Wisconsin Society of Internal Medicine.

William Pagano, MD

. . . Sun Prairie, recently became associated with the Sun Prairie Clinic. Doctor Pagano graduated from George Washington University Medical School and took his family practice residency at the University of Wisconsin Medical School in Madison. Other MDs at the clinic are Joseph Behrend,* Wm T Russell,* Mary Schmidt* and John Allen.*

Thomas F Nikolai, MD*

. . . Marshfield, has been named to a second four-year term as a member of the Governing Council of the Wisconsin Society of Internal Medicine.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1978

1 WisPRO Criteria Committee
1 Health Care Coalition
3 Joint Practice Committee
3 Records Committee-Wisconsin Immunization Initiative Committee
6 Dane County Medical Society HMP
6 Public Relations Committee
6 Auxiliary Finance Committee
7 Dane County Medical Society Board of Trustees
7 Wellness Discussion
8 SMS Commission on Governmental Affairs
8 SMS Committee on Federal Legislation
8 SMS Committee on Environmental Health
8 CESF Executive Committee
9 WHCRI Board of Directors
10 Legislative Committee-Wisconsin Public Health Association
13 Madison Orthopedic Society
14 WisPRO Review Coordinator Conference
15 WisPRO Executive Committee
15 WisPRO Board of Control
15 SMS Committee on Occupational Health
16 Council of Professions
16 Ad Hoc Committee to Study Quality Care Activities
16 Health Intern Meeting
17 Subcommittee on Accreditation
17 WisPRO CME Club
21 Southwest Physicians Task Force on Health Planning
23 Madison Society of OB-GYN
23 SMS Committee on School Health
31 Executive Committee of the SMS Council

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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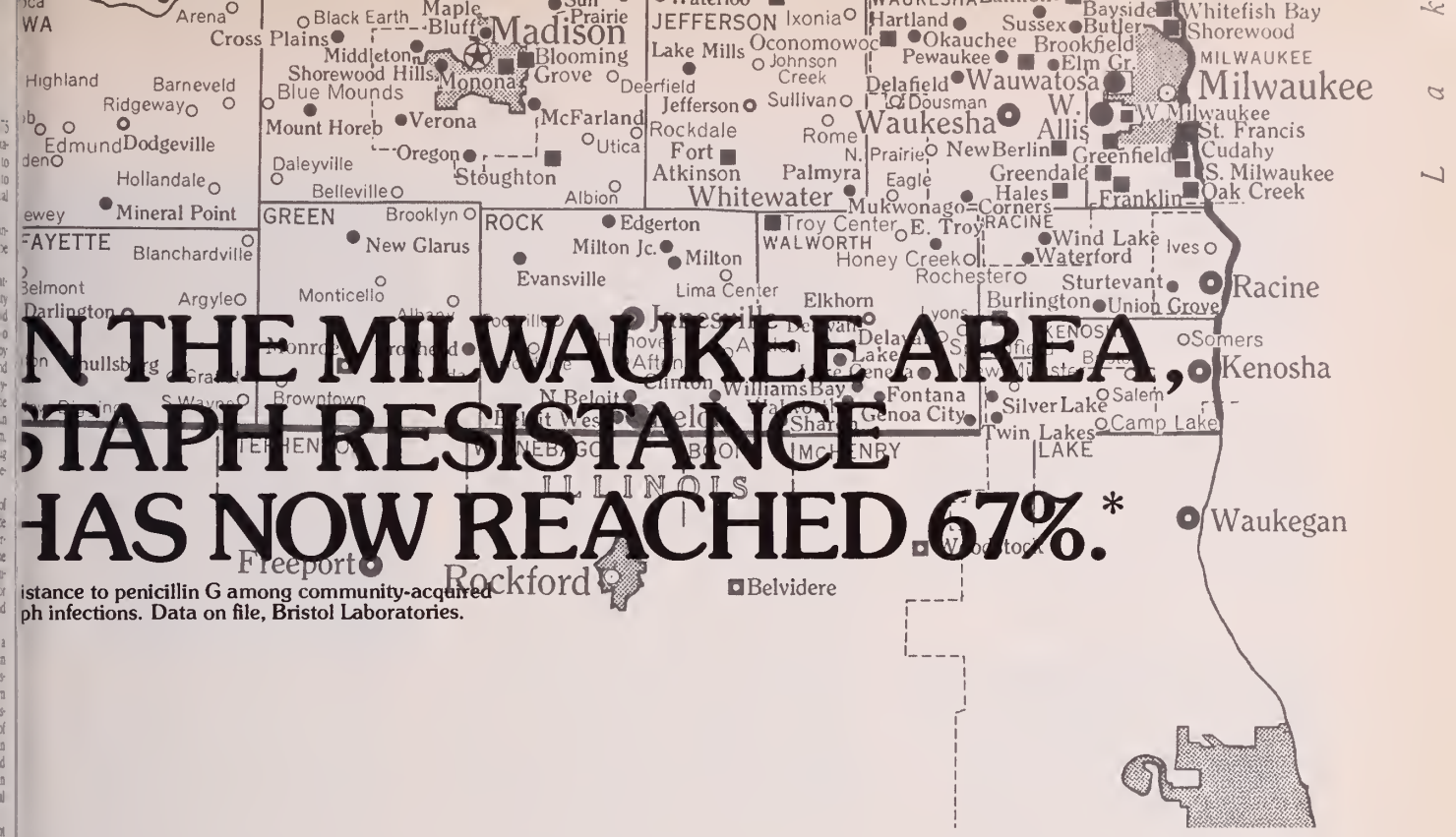

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F John Gouze, MD*

. . . Marshfield Clinic cardiologist, was honored earlier this year on the occasion of his retirement as a director and shareholder of the clinic, after 30 years. He remains on the medical staff as an active physician, however.

Harold J Kief, MD*

. . . Fond du Lac physician for 40 years, recently retired from his general practice with Associated Physicians of Fond du Lac. He recently was honored for his medical career and services to his community by the State Medical Society of Wisconsin and the Fond du Lac County Medical Society. Doctor Kief served as the 112th president of the State Medical Society and also was president of the Fond du Lac County Medical Society. He served as a delegate from the Sixth Councilor District and was a member of the State Medical Society's Council for eight years. He had been vice-speaker of the House of Delegates, member of the Council on Medical Service, and an advisor to the American Association of Medical Assistants Inc—Wisconsin Society. As a councilor of the State Society, Doctor Kief was a member of the Executive Committee and chairman of the Planning Committee. Doctor Kief served as Public Health Officer of Fond du Lac for 18 years, was chief-of-staff of St Agnes Hospital, and has been a member of the Health and Social Services Board of the State of Wisconsin since 1968, of which he served as vice-chairman for four years.

HAROLD J KIEF, MD, left, and h wife Mary, right, were guests honor during a "tribute" by th State Medical Society of Wiscons and the Fond du Lac County Medic Society. Earl Thayer, center, exec tive secretary of the State Societ was the guest speaker. (FOND D LAC REPORTER photo)

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FAMILY PRACTITIONER WANTed to join 11-man group. Many corporate benefits. Rapidly growing community of 20,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, PO Box 178, West Bend, Wis 53095. 2tfn/78

ASSISTANT DIRECTORS—Family Practice Faculty, Assistant Directors and Clinical Teachers are needed for Family Practice residencies in Madison, Waukesha, Eau Claire, and Wausau, Wisconsin. All programs affiliated, state university system. Teaching and patient care program in expanding model clinics and in community hospitals provides a stimulating environment in several Wisconsin communities. Excellent salaries and liberal fringe benefits. Send resumé to: John H Renner, MD, Chairman, Dept of Family Medicine and Practice, 777 S Mills St, Madison, Wis 53715. An Equal Opportunity Employer. 3-4/78

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FOR SALE: OFFICE AND MEDICAL equipment of deceased doctor who was engaged in general practice and surgery in the Village of Waterford, Racine County, Wis. Call: 414/539-2868. gltfn/78

FOR RENT: OFFICE SPACE USED by general practitioner prior to his death in the Village of Waterford, Racine County, Wis. Call: 414/539-2868. gltfn/78

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CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 Wisconsin

May 12-13: Twentieth meeting, *Wisconsin Neurological Society*, at Holiday Inn, Stevens Point. Open to all interested physicians and allied health personnel. Approved for Category I credit. WNS is accredited for CME. Program chairman: Francis M. Forster, MD, Madison (phone 608/262-1999).

May 5-6: Shareshop on epilepsy—*Practical Modern Approaches to an Ancient Disorder—Epilepsy*, sponsored by Wisconsin Epilepsy Association, University of Wisconsin-Madison Medical School, and UW-Extension, Health Sciences Unit, Department of Continuing Medical Education, at the University Bay Center, Madison. Meets criteria for 16 credit hours in Category I of AMA-PRA. Conference cost for physicians: $70. Further info: Aleta Barmore, Executive Director of the Wisconsin Epilepsy Association, 1245 East Washington Ave, Madison, Wis 53703; tel 608/255-9009.

May 11-13: International conference: *Heart Disease and Rehabilitation—State of the Art 1978*, at the Marc Plaza Hotel, Milwaukee. Presented by Mount Sinai Medical Center (Cardiovascular Disease Section), Milwaukee in cooperation with the University of Wisconsin-Madison, School of Medicine; the American Heart Association, Wisconsin Affiliate; the UW-Milwaukee, and the Dept of Continuing Medical Education Health Sciences Unit University of Wisconsin Extension Program fee $200 for physicians and $75 for nonphysicians. Info: Public Relations Dept, AHA/WA, 795 North Van Buren, Milwaukee, Wis 53202; (414)271-9999.

May 18: *First Annual Spring Cancer Conference* at The Abbey on Lake Geneva, Fontana, Wis. Acceptable for 6 credit hours of Category I of AMA-PRA and 6 credit hours by the AAFP. Info: Registration deadline, May 4, 1978, $10.00 per person. Make check out to Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

May 18-20: *The Family in Treatment: A National Conference on Family Therapy*, Marc Plaza Hotel, Milwaukee. Tuition: $100. Approved for 13 Category I CME Credit Hours and 13 Elective AAFP Credit Hours. Contact: Dr Ross E Carter, Dept of Psychiatry and Mental Health Sciences, Medical College of Wisconsin, 9191 Watertown Plank Road, Milwaukee, Wis 53226.

May 19-20: *Emergency Problems in Pediatrics*, UW-Madison.

May 19-20: *Medical/Surgical Update—1978*, at Marshfield Clinic. See details in box elsewhere in this issue.

May 19-21: *Medicine of the Whole Person*, presented by American Holistic

(Surgery—Vascular)

The Noninvasive Vascular Laboratory and the Surgical Management of Common Vascular Problems

For: Family Practitioners, General Surgeons, Peripheral Vascular Surgeons, Nurses, and Noninvasive Blood Flow Technicians. Symposium, **June 9-10, 1978,** Oak Brook Hyatt House, Oak Brook, Ill. Hours of instruction: 11, CME Credit-AMA Category I. Fee: $125.00. Registration limit 300. Sponsor: University of Health Sciences/ The Chicago Medical School, Chicago, Ill. Contact: Cheryl Kinczyk, Symposium Coordinator. Tel: 313/689-1045. 4/78

Medicine Association and Biogenic Institutes of America (a not-for-profit foundation dedicated to health) in conjunction with and cosponsored by the American Society of Contemporary Medicine and Surgery, which certifies that this continuing medical education offering meets the criteria for 9 credit hours in Category I of the AMA Physicians Recognition Award. Contact Biogenic Institutes of America, Inc, Route 2, Welsh Coulee, LaCrosse, Wis 54601; 608/786-0611.

May 20: American Diabetes Association/Wisconsin Affiliate, and the Southern Wisconsin Diabetes Association Joint Annual Meeting at Sheraton Inn in Madison. See further details in box elsewhere in this section.

JOINT ANNUAL MEETING

American Diabetes Association/ Wisconsin Affiliate, and Southern Wisconsin Diabetes Association

Saturday, May 20, 1978
Sheraton Inn, Madison, Wisconsin

There will be both lay and scientific programs. All interested persons are welcome to attend any of the activities. The scientific program is primarily for physicians and paramedical personnel interested in diabetes.

RETINOPATHY: COMPLICATIONS AND THERAPY

2:00—*Coping with Complications*, by Dr Leo Krall, Internal Medicine, Joslin Diabetes Foundation, Boston

2:30—*Clinical Factors Altering the Natural Course and Laser Photocoagulation Responsiveness of Diabetic Retinopathy*, by Dr Lloyd Aiello, Director, Beetham Eye Unit, Joslin Clinic, Boston

3:15 to 5:00—Round Table Discussion: *Complications of Diabetes*. Dr M D Davis, moderator; Dr Lloyd Aiello; Dr J M B Bloodworth Jr; Dr Robin L Ewart; and Dr Leo P Krall

5:00—Preprandial

6:30—Southern Wisconsin Diabetes Association Dinner (Dutch-treat)

7:30—5th Annual UPJOHN LECTURE: *Ocular Complications of Diabetes Mellitus and Their Treatment*, by Dr Lloyd Aiello

For Dinner reservations, send check for $6.00 to Mrs. Betty Roberts, 1010 Mound Street, Madison, Wis 53715 (checks should be made out to Mrs Roberts).

May 26: University of Wisconsin Medical Alumni Day, Madison.

May 28: University of Wisconsin Commencement, Madison.

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1978 NEIGHBORING

Apr 27-28: *Frontiers in Aging: Life Extension* conference, Radisson-St Paul, Minn. Multidisciplinary conference sponsored by the All-University Center on Aging and conducted by the Department of Conferences at the University of Minnesota. Robert Butler, director of the National Institute on Aging will make the keynote address, "Why Survive 2078?" Info: David Chittenden, Program Director, 219 Nolte Center, 315 Pillsbury Drive SE, University of Minnesota, Minneapolis, Minn 55455; (612)376-2578. g3/78

May 10-12: *Nuclear Medicine for the Internist*, Mayo Clinic and Mayo Foundation, Rochester, Minn. American College of Physicians postgraduate course, approved by AMA Advisory Committee on CME, may be used to fulfill 18½ hours of Category I requirements for AMA-PRA. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia, Pa 19104. g3-4/78

First Annual Spring Cancer Conference

Thursday, May 18, 1978

The Abbey on Lake Geneva/Fontana, Wisconsin

am		
7:30	Registration	
8:00	Welcome—*Paul P Carbone, MD*	
8:05	Pre-Test*—*Paul C Tracy, MD*	
8:30	Reliable Screens—*Richard R Love, MD*	
9:00	Mammography—*Raul H Matallana, MD*	
9:30	Nuclear Medicine—*Robert E Polcyn, MD*	
10:00-11:05	Breast Workshop Group A *Alvin J Greenberg, MD* Chairperson *Robert O Johnson, MD* *Raul H Matallana, MD* *Douglass Tormey, MD*	Lung Workshop Group B *John R Pellett, MD* Chairperson *Ernest C Borden, MD* *Joyce C Kline, MD*
11:10-12:15	Repeat Workshop Group B	Repeat Workshop Group A
pm		
12:30	Luncheon with Guest Speaker *William L Donegan, MD, Surgical Aspects of Early Carcinoma*	
2:00-3:10	Gastrointestinal Workshop Group A *William H Wolberg, MD* Chairperson *Hugh L Davis, MD* *Albert L Wiley, MD*	Gynecology Workshop Group B *Dolores A Buchler, MD* Chairperson *Thomas E Davis, MD* *Mojmir G Sonek, MD*
3:10-4:20	Repeat Workshop Group B	Repeat Workshop Group A

*This program is part of the evaluation process which is required under terms of the NCI grant. Participants will be pre- and post-tested to assist in evaluation of the effectiveness of the conference.

Acceptable for 6 credit hours of Category I of AMA-PRA and 6 credit hours by the AAFP.

INFO: Registration deadline, May 4, 1978; $10.00 per person. Make check out to Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

MARSHFIELD CLINIC
ST JOSEPH'S HOSPITAL
MARSHFIELD MEDICAL FOUNDATION

present

Medical/Surgical Update—1978
Friday and Saturday, May 19-20
at Marshfield Clinic
Marshfield, Wisconsin

PROGRAM

Friday, May 19

8:30—Registration

9:00—Welcome: Thomas F Nikolai, MD, Program Coordinator; Gerald E Porter, MD, President, Marshfield Clinic

9:10—Recent Advances in the Therapy of Asthma, Raymond L Hansen, MD

9:30—Immunity and the Lymphocyte, Joseph J Mazza, MD

10:00—Management of Thyroid Nodules and Malignancy in Those With a History of Childhood Radiation Therapy, Alan K McKenzie, MD

10:40—Colon and Rectal Polyps; Diagnosis and Treatment, Robert G Norfleet, MD

11:00—Seizures in Children, Stephen C Zinsmeister, MD

11:20—Recognition and Therapy of Depression, Michael T Wood, MD

11:40—Drug Eruption, Donald J Miech, MD

12:00—Lunch

1:00—The Increasing Difficulty in the Diagnosis of Hyperthyroidism, Thomas F Nikolai, MD

1:30—Nongonococcal Urethritis, Ray C Haselby, DO

1:45—Legionnaire's Disease, John D Lee, MD

CONCURRENT SESSIONS

Session 1

2:00—Skin Diseases That Reveal Internal Disease, William F Schorr, MD

2:25—Evaluation and Management of Dementia, Phillip M Green, MD and Philip G Zerfas, PhD

3:10—Clues to Proper Interpretation of Heart Sound and Murmurs, Richard H Ulmer, MD

3:35—Indications and Contraindications to Hyposensitization, Robert M Heywood, MD

4:00—Coronary Artery Revascularization Surgery—Does It Really Help?, Dean A Emanuel, MD

Session 2

2:00—Resuscitation of the Newborn, James C Opitz, MD

2:25—Office Gynecology, Thomas J Rice, MD

3:10—Management of Anal and Rectal Problems, Constante S Avecilla, MD

3:35—Potpourri of Wound Care, Marvin E Kuehner, MD

4:00—Acute Diverticulitis: Medical and Surgical Management, Jerry M Hardacre, MD

7:00—Preprandial

7:30—Dinner

8:30—Evening Program: The China Connection, Ben R Lawton, MD, MD's Trip to the Forbidden Land

Saturday, May 20

CONCURRENT SESSIONS

Session 1

8:30—Computerized Axial Tomography, Edgar L Koch, MD

8:55—Echocardiography, Linley E Watson, MD

9:20—Abdominal Ultrasonography, Dayton H Hinke, MD

Session 2

8:30—Ocular Trauma and Emergencies, George M Sparks, MD

8:55—Hyperalimentation, William M Toyama, MD

9:20—Cranial Arteritis and Polymyalgia Rheumatica, Kenneth P Wolski, MD

General Session

10:00—Pending National Health Insurance Legislation, G John Weir, MD

10:30—Radiology and Pathology Conference, Cesar N Reyes, MD and William A Smullen, MD

Advanced registration is required. Deadline for registrations is May 12. Fee: $25 which includes lunch on Friday. Enrollment limited to first 150 physicians and their spouses.

Program approved for 8 hours of credit from the WAFP. Also approved for 8 hours of CME Category I credit by the AMA-PRA.

A spouse's program also has been planned for Friday. Fee: $7.50.

Further information: Office of Medical Education, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, Wis 54449.

May 19-20: Iowa Regional Meeting of the American College of Physicians, at University Hospital (William B Bean Auditorium), Iowa City, Ia. Attendees eligible for credit toward AMA-PRA in Category I. Info: Leslie W Swanson, MD, FACP, Forest Park Medical Clinic, 1023 Second St, SW, Mason City, Iowa 50401. g3-4/78

May 22-24: *Hematology Update 1978,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

HEART DISEASE AND REHABILITATION—STATE OF THE ART

International conference at the
MARC PLAZA HOTEL/MILWAUKEE

May 11-12-13, 1978

Presented by Mount Sinai Medical Center (Cardiovascular Disease Section), Milwaukee, in cooperation with the University of Wisconsin-Madison, School of Medicine; the American Heart Association/Wisconsin Affiliate; University of Wisconsin-Milwaukee, and Dept of CME Health Sciences Unit-UW Extension.

A faculty of 41 men and women, representing 19 states, Canada, and Sweden will address the symposium.

Physicians, physiologists, physical educators, nurses, and therapists from across the United States and abroad will attend.

Focus will be on the epidemiology and pathophysiology of heart disease, with examination of the medical and surgical options that are available for the treatment of heart disease. The role of exercise-based rehabilitation programs in the management of heart patients also will be explored.

Program is accredited by the UW-Extension, Dept of CME, for 2.0 CEUs. Offering has been approved for 24.6 contact hours by the WNA-CEARP Committee. AMA Category I 20 credits towards AMA-PRA.

Registration deadline: April 7.

Program fee $200 for physicians and $75 for nonphysicians. Further info and for registration forms, contact the Public Relations Dept, AHA/WA, 795 North Van Buren, Milwaukee, Wis 53202; phone 414/271-9999.

May 23-24: *Hematology Update 1978,* Mayo Clinic, Rochester, Minn. American College of Physicians (ACP) postgraduate course, approved by AMA Advisory Committee on CME, may be used to fulfill 19½ hours of Category I requirements for the AMA-PRA. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine St, Philadelphia, Pa 19104. g3-4/78

The Family in Treatment: a National Conference on Family Therapy

sponsored by the Medical College of Wisconsin, Milwaukee at the Marc Plaza Hotel

Thurs-Sat, May 18-20, 1978

Cosponsors with MCW's Dept of Psychiatry and Mental Health Sciences are Columbia Hospital, Milwaukee Psychiatric Hospital, Milwaukee Mental Health Consultants, and Wood Veterans Administration Center.

Conference is open to psychiatrists, psychologists, social workers, and other allied mental health professionals.

Sixteen different small group seminars on family therapy techniques will be offered including seminars on the treatment of families with hospitalized children, child abusing families, and family therapy with alcohol problems and divorce.

Major addresses include: *The Trained Spontaneity of the Family Therapist,* by Salvador Minuchin, MD, professor of child psychiatry and pediatrics, University of Pennsylvania, and director, Family Therapy Training Center of the Philadelphia Child Guidance Clinic; *The Differentiation of Self,* by Murray Bowen, MD, director of the family center and professor of psychiatry, Georgetown University School of Medicine; and *Therapy with 'Resistant' Families and 'Resistant' Settings,* by Lyman Wynne, MD, PhD, professor of psychiatry, University of Rochester.

Conference has been approved for 13 hours of Category I Credit towards AMA-PRA and program is acceptable for 13 elective hours by AAFP.

Advance registration required. Tuition fee: $100. Info: Ross E Carter, PhD, Director, Division of Family Therapy, Dept of Psychiatry and Mental Health Sciences, MCW, 9191 Watertown Plank Road, Milwaukee, Wis 53226; (414) 964-5100.

1978 OTHERS

June 17-18: Fifth Annual UCLA Biofeedback Seminar: *Practical Applications of Biofeedback in the Health Sciences,* at Los Angeles Marriott Hotel, Los Angeles, Calif. Approved for 12½ hours of Category I credit toward CMA Certificate in CME and the AMA Physicians Recognition Award. Fee: $185. Info: Health Sciences, UCLA Extension, PO Box 24902, Los Angeles, CA 90024 or call 213/825-5840. g3-5/78

Sep 11-13: American Cancer Society *National Conference on the Care of the Child with Cancer,* at The Sheraton-Boston Hotel, Boston, Mass. Attendance open to all members and students of the medical, nursing, and related health professions. Advance registration requested. No registration fee. Accredited for CME. Info: Sidney L Arje, MD, ACS, 777 Third Ave, New York, NY 10017. g3-8/78

Dec 5-9: *Fluid and Electrolyte Balance, Hypertension and Renal Disease,* American College of Physicians Postgraduate Course, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Ill. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

AMERICAN MEDICAL ASSOCIATION

127th Annual Convention

June 17-22, 1978—St Louis

I. Scientific Program—St Louis Gateway and Exhibition Center

—Scientific and industrial exhibits, Saturday thru Wednesday

—Postgraduate courses, Saturday thru Wednesday

—General scientific session, Saturday thru Wednesday. (The complete convention program is available in the April 17 issue of the *JAMA.*)

II. House of Delegates—Chase-Park Plaza Hotel

—The bi-annual session of the House of Delegates will commence Sunday, June 18. The House will continue to meet daily thru Thursday.

INFO CONTACT: AMA Housing Bureau, % St Louis Convention & Visitors Bureau of Greater St Louis, 500 North Broadway, St. Louis Mo 63102; or Ms Debbie Sweet, AMA Public Relations, 535 North Dearborn, Chicago, Ill 60610; or phone 312/751-6601.

CONTRIBUTIONS—CES FOUNDATION
February 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1978.

Unrestricted

Robert T Cooney, MD; Ashland-Bayfield-Iron County Medical Auxiliary; Sheboygan County Medical Auxiliary—*Voluntary Contributions*

Restricted

Merck & Co, Inc—*Scientific Teaching General*
American Family Insurance Co; Wyeth Laboratories—*Medical Student Summer Externship Program*
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Membership Dues—*Aesculapian Society*

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FILM STRESSING NEED FOR IMMUNIZATION AVAILABLE

"A Gift, An Obligation," an American Academy of Pediatrics' film stressing the importance of childhood immunizations, is now available on a free-loan basis for presentation at local medical society or community meetings, in health education classes, or for use in health departments and health clinics. The half-hour film uses a series of vignettes portraying the birth and early lives of several child victims during the first half of the century to remind audiences of the often tragic consequences of such diseases as whooping cough, measles, diphtheria, mumps, and polio. Companion information kits containing additional information about immunizations for distribution to local audiences may be requested with the film. To borrow or purchase a copy of the film, (copies may be purchased for an at-cost price of $90 a print), write: Claire Walsh, Vice President of Operations, West Glen Communications, Inc., 565 Fifth Ave., New York, NY 10017.

EXPANSION OF BUREAU FOR CRIPPLED CHILDREN SERVICES

Historically, the Bureau for Crippled Children (BCC) in the Division for Handicapped Children, State Department of Public Instruction, has not provided payment to hospitals for inpatient services for the children they are serving except at the University Hospitals in Madison. Now, on a pilot basis, authorization for the payment of certain hospitalization costs are being done in several hospitals.

Conditions under which such authorizations are being made are: (1) family has no hospitalization insurance and is not eligible for Medical Assistance; or (2) family has insurance but child is excluded from policy; or (3) family has insurance and child is covered but maximum benefits for that illness have been exhausted; (4) the illness or condition is included in the Bureau for Crippled Children state plan; and (5) prior authorization from BCC, 126 Langdon Street, Madison, WI 53702, has been obtained.

Hospitals participating in the project are: Bellin Memorial Hospital, Green Bay; St Vincent's Hospital, Green Bay; Milwaukee Children's Hospital, Milwaukee; LaCrosse Lutheran Hospital, LaCrosse; and St Joseph's Hospital, Marshfield. If the project is successful, it is anticipated this type of service will be expanded to other hospitals.

DRUGS ADDED TO GENERIC DRUG FORMULARY

The Wisconsin Department of Health and Social Services has added nine drugs to the Wisconsin Generic Drug Formulary (Chapter H 27 of the Wisconsin Administrative Code). Drugs added to the list are: amoxicillin, an antibiotic; dioctyl sodium sulfosuccinate with casanthranol, a laxative; diphenoxylate, a drug used in the treatment of diarrhea; hydrochlorothiazide, a diuretic; penicillin G potassium, an antibiotic; promethazine HCl, a drug used in the treatment of allergies; propantheline bromide, a drug used in the treatment of peptic ulcers; rauwolfia serpentina, a drug used to treat hypertension; and tripelennamine HC1, an antihistamine.

REPRINTS OF AMA AD CAMPAIGN AVAILABLE TO PHYSICIANS

In late March the AMA launched an advertising effort stressing the positive values of American medicine and the service provided to patients by physicians. Every AMA member physician has been mailed a flyer which describes the campaign, gives pictures of the first four advertisements, and gives the physician the opportunity to order full-size reprints of the ads along with a mounting easel at no charge. To order the ad reprints and/or the easel to display the ads on a counter or tabletop, write to: Department OPR-1, AMA, 535 North Dearborn Street, Chicago, Illinois 60610. ■

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal.* the official publication of the Society.

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN MEDICAL JOURNAL
1903 - 1978 75th ANNIVERSARY YEAR

Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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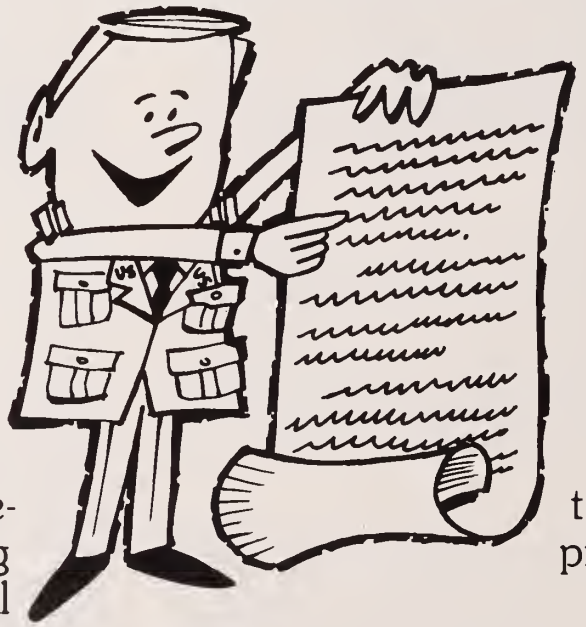

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SMS COMMENTS ON STATE HEALTH PLAN

Charging that many sections of the 1978 State Health Plan were "poorly written, naively presented, and the product of authors who have done much of their work through literature review and very little of it in consultation with the physician professional," SMS Secretary Earl Thayer asked that state health planning leaders not take final action on the plan until October or November of this year in order to provide adequate time to revise it.

Testifying in Madison on behalf of SMS at an April 27 public hearing on the proposed 1978 State Health Plan, Thayer emphasized that while the Society has long been an advocate of "sound and reasonable planning for Wisconsin health care services," the present draft of the State Health Plan is "disappointing in several respects." Federal Law PL 93-641 mandates that the State Health Plan be made up of the Health Systems Plans of the Health Systems Agencies (HSAs) at the local level. Thayer pointed out in his testimony that most HSA Plans were not prepared in time to provide the background recommendations on which to base the State Health Plan. He said there has not been sufficient input by health professionals during the development of the Plan, and "in effect, local interest and health professionals have been disenfranchised from the planning process."

Finally, Thayer stressed the necessity to add a fiscal note to each goal, objective, and recommendation contained in the Plan. In its present form, the Plan makes periodic references to "resource requirements" which only address the impact of the planning activity on the Department of Health and Social Services and completely ignores any operational costs of the Plan. The Society submitted a written position paper on the State Health Plan at the April 27 hearing which includes specific comments to each of the Plan's sections.

GOVERNOR SIGNS ANTI-ABORTION BILL

Acting Governor Schreiber has signed Assembly Bill 1272 which cuts off public funds for abortion except in certain circumstances. The new law prohibits any public funds to be used for abortions unless the abortion is directly and medically necessary to save the life of the woman, or in cases of sexual assault or incest, or where the abortion is necessary to prevent "grave, long-lasting physical health damage" to the woman. A physician is required to certify the direct medical necessity of such abortion upon his or her best clinical judgment.

DIVISION OF HEALTH GETS NEW CHIEF

State Department of Health and Social Services Secretary Donald Percy, recently appointed Robert Durkin to head the Department's Division of Health. Durkin, a former labor official from Milwaukee, had been serving as Acting Director of the division since the departure of former administrator Ralph Andreano last March.

GOVERNOR SIGNS FRIVOLOUS SUIT BILL

In late March, Acting Governor Martin Schreiber signed into law Assembly Bill 237, which establishes a general frivolous lawsuit statute for all legal actions in Wisconsin. This legislation has been a high priority bill for the State Medical Society because it can be an important economic deterrent for attorneys. If a court determines that an action is without any basis in law or equity, the case can be dismissed and *actual* defense costs can be recovered from the party bringing the action, the attorney, or both the party and the attorney. It should be noted, however, that the frivolous standard applies to counterclaims, cross complaints or defense as well. This legislation will apply to medical liability cases after April 6, 1978 and should prove to be important in clearing the courts of unfounded or harassment suits. ■

Hypertension

MAY IS NATIONAL Hypertension Month. Included in this issue is a special article, "Hypertension Control in Wisconsin," by Doctors Kochar and Itskovitz and another on oral contraceptive induced hypertension by Doctors Raj and Kochar.

The article on hypertension control points out that well over fifty million people in the United States may have elevated blood pressure. These statistics applied to Wisconsin indicate that there may be approximately one million people in the state with elevated blood pressure. The Milwaukee Blood Pressure Program is almost five years old and participants have screened a large segment of the population for hypertension. A newer statewide hypertension control effort has just been launched. This program deserves and needs the cooperation of all Wisconsin physicians. In addition to hypertension control the three old fates, obesity, heavy smoking, and elevated cholesterol, will be considered along with excessive alcohol consumption.—VSF

Perinatology progress

IN THE MARCH 1978 issue of the *Wisconsin Medical Journal* there was an article entitled "The Impact of Perinatal Intensive Care and Regionalization in Wisconsin." The program described began ten years ago and the results of the regionalization efforts have indeed been dramatic.

Even prior to the program, Wisconsin was found to have relatively low neonatal mortality rates in the Hyaline Membrane Disease/Respiratory Distress Syndrome. Subsequently, the rate has declined yearly and has been well below the national average by 25 to 44%.

This study emphasizes and augments the many years' work and excellent record of the Committee on Maternal and Child Health. This committee has long been a dedicated group and has played an invaluable role in maintaining Wisconsin's excellent standing in maternal and perinatal mortality statistics. It is anticipated that the programs will continue and that the already excellent records will be maintained or surpassed.—VSF

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In Editarials, the views expressed, if initioled or signed, are those of the writer ond not necessarily officiol positions of the Society.

Better late, but with apologies

THE ANCIENT ADAGE "Better late than never" really shouldn't apply to the *Wisconsin Medical Journal.* The March issue contained a great deal of information pertinent to the annual meeting in Milwaukee. Unfortunately, the issue arrived on April 12th just a day prior to the state meeting.

Although the US Postal Service is the usual whipping boy in late deliveries, in this case the delay rests entirely with our printers in Kentucky. On March 13th we requested delivery of the March issue by March 23rd. We were assured that it would be in the mail by March 31st which still would have been acceptable. However, it was a week beyond that date when it was finally mailed second class on April 7th. Then there followed the five days in transit between Louisville and Wisconsin.

Several years ago the printing contract for the Journal was let out of state simply because of economics. The savings each year amount to thousands of dollars which makes it worthwhile despite the inconveniences in mailing manuscripts, proofs, etc, back and forth.

So far we haven't fallen into the situation of the medical journal from a southern state which at one point was five to six months behind schedule and at one time had three issues at the printers. The staff apologizes for the late arrival of your Journal. The material for the April issue was at the printers early in the month and it will be interesting to see when it is delivered.—VSF

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

Cites government's increasing role in medical practices

To the Editor: Examining the April issue (of the *Wisconsin Medical Journal*) gave me an opportunity to view the increasing role of government in our medical practices. I would like your readers to refer to pages 7, 31, 32, and 56.

Page 7—The three lead headings were as follows:
(1) New sterilization regulation in effect,
(2) Medical Examining Board relaxes amphetamine rule,
(3) Reminder: New State Lab billing procedure in effect.

Pages 31-32—The following were noted:
(1) State Health Plan aired at public hearing,
(2) MDs and SMS Staff learn art of negotiating,
(3) SMS continues its opposition to health planning guidelines,
(4) Justice Department initiates "inquiry" of medical societies.

Page 56—Add the following:
(1) Expansion of Bureau for Crippled Children services,
(2) Drugs added to Generic Drug Formulary.

Add to the above "government related articles" the many "other regulatory aggravations" of every day practice, and we must agree that sooner or later the individual physician becomes discouraged and angry. Each day there are new EDS regulations, new rules under PSRO, HSA health plans, DHSS bulletins, and mandates, etc.

Presently the SMS, through its Physicians Alliance, is negotiating a contract to be signed by all physicians to ALLOW them to be reimbursed for Title 19 patient care. Should we be negotiating for contracts with rules and regulations that are less repressive than if we didn't negotiate a contract? It would appear that a contract is a contract regardless of content. Haven't we seen what contracts have done in New York and California?

It is my hope that all physicians STOP—LOOK—LISTEN. This contract is unprecedented, unnecessary, and unworkable. Will we succumb to *control* in return for financial reward? I believe sincerely that this is the battleground! Will Wisconsin physicians be participants or nonparticipants? Each physician must decide by July 1, 1978.

GERALD J DERUS, MD
May 1978 Madison ■

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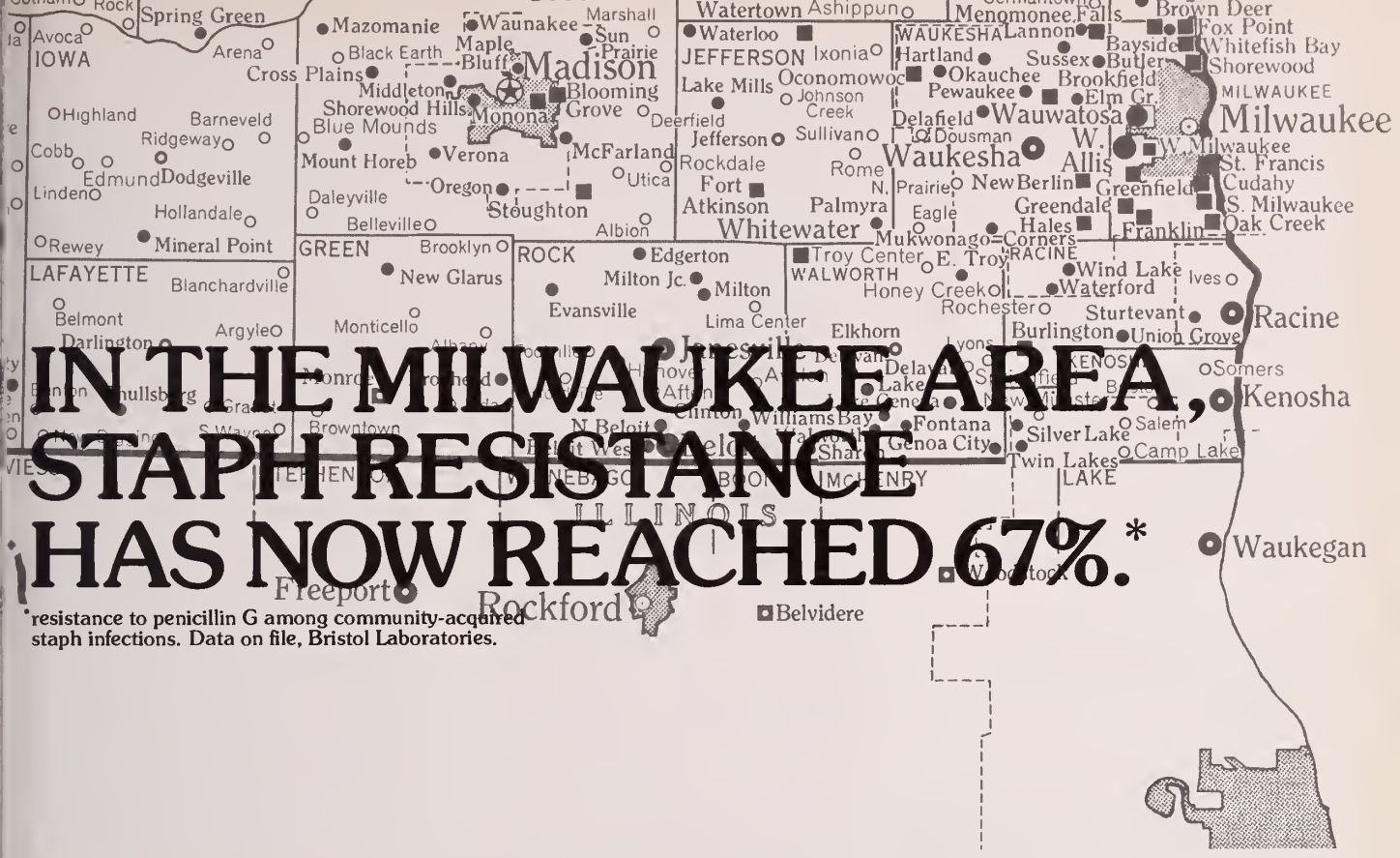

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Cancer epidemiology

Part 11

Breast cancer

BREAST CANCER is the largest cause of cancer death among women in North America, killing approximately 35,000 women in the United States each year. The incidence of breast cancer varies widely throughout the world, with women in North America and northern Europe having five to six times greater incidence than women in Asia and Africa.[1] This geographic difference is probably not genetically determined, since cancer rates of migrants and their daughters gradually reach that of the host population.[2]

Age incidence curves in most of the high-risk countries show an increase throughout life, while in the low-risk countries there appears to be an increasing incidence until middle life, then a plateau, and a gradual decline after age 50.[3] An interesting finding in the high-risk areas is the "Clemmesen Hook." This is a decrease or plateau in the incidence curve which occurs between 50-54 years of age. It suggests that there are two distinct etiologies which contribute to breast cancer incidence, one associated with the pre- and the other with the post-menopausal periods of a woman's life.[4]

In Wisconsin, the counties around Milwaukee, LaCrosse, and Green Lake have mortality rates which are significantly higher than those for the rest of the country.[5] It has been shown that Jewish women have twice the risk of non-Jewish,[6] and Japanese 1/5 that of U.S. white women.[2]

A woman with a primary lesion in one breast has an increased chance (4-20%) of developing a second primary lesion in the other breast.[7] Breast cancer is also associated with an increased incidence of cancer of the endometrium, ovary, colon, salivary glands, and with acute myelogenous leukemia.[8] Diabetes, hypertension, repeated fluoroscopies, and exposure to radiation (used for diagnosis, radiotherapy, or following atomic bomb explosions) are associated with an increased risk of breast cancer.[9-12]

Studies done of familial aggregations show that female relatives of a woman with breast cancer have a 2-3 times greater risk of breast cancer than the general population. The risk increases 3-fold for relatives of premenopausal breast cancer patients and 5.4-fold for relatives of bilateral breast cancer patients. Relatives of patients who had both premenopausal and bilateral cancer have a relative risk factor of almost 9. Sisters of breast cancer patients whose mothers also had the disease have an increased risk.[13]

Various factors involving a woman's reproductive history have been associated with breast cancer.[14] These factors appear to be related to the fact that the risk of breast cancer is directly related to the age at which a woman bears her first full-term child.[15] Women who have their first child before age 18 have one-third the breast cancer rate of those who have their first delivery after age 35. Women who have their first delivery before age 30 have a lesser risk than nulliparous women, but those who deliver after 30 have a greater risk. While increased family size has been associated with a decreased risk of breast cancer, this relationship is not due to the number of children but rather to the fact that women with large families tend to have their first child earlier. Lactation has been associated with decreased breast cancer risk for many years; however, recent studies have shown little if any protective effect.[16-17] Surgical menopause reduces the risk by as much as 60%, especially if before age 35.[2] Early menarche has been associated with increased breast cancer, as has late menopause (over 55).[18-20] This increased risk strongly suggests that the level and duration of exposure of the individual to ovarian activity is an important factor.

Gross cystic disease is the most common lesion of the breast and occurs in up to 40% of women. Because these are palpable tumors, they can be correlated with the subsequent development of breast cancer. Although there is still some debate, several reports indicate that women with gross cystic disease have about 1.7-4 times the amount of breast cancer expected.[21-26] The site of cancer development has no relationship to the site of cystic disease.

Multiple intraductal papillomas are precancerous. A special apocrine papillary and cribriform type of cancer is associated with this disease. It has a slow and tenacious course.

The third type of breast lesion which may predispose a woman to cancer is lobular neoplasia, also called lobular carcinoma in situ or epitheliosis. It is a lesion which evolves in premenopausal breasts, then apparently regresses and disappears after the menopause. It does not metastasize. However, it does predispose to carcinoma. Invasive cancer may start from about 10% of these lesions after 5 years, 15% after 10 years, and 30% after 15 years; or the chance of developing cancer during a subsequent

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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4-25 year period is approximately 25% for the breast in which lobular neoplasia in situ was found and 8.5% for the contralateral breast.

Rarely cystosarcoma phyllodes may predispose to cancer, but other forms of benign breast lesions are not considered to be precancerous.

Dietary fat has been associated with an increased incidence of breast cancer. Persons in countries with a low incidence of breast cancer generally consume less animal and dairy fat.[2,9,27] There may be more breast cancer in women who are tall and heavy.[28]

There has been considerable concern about a possible relationship between exogenous estrogen administration and breast cancer. A few case control studies have failed to demonstrate any relationship between the intake of estrogens alone or in combination (oral contraceptives) and breast cancer.[29-32] Prolactin, progesterone, and estrogens have all been suggested as possible carcinogenic agents.[33] The excess risk of breast cancer reported in long-term reserpine users may be associated with increased prolactin secretion, but there have been no good case control studies supporting this.[34] Progesterone is a co-carcinogen in animals, but produces a protective effect in women with late menarche and early menopause. In fact pregnancy produces high levels of progesterone but is not associated with increased risk.

Human estrogens (estrone, estradiol, and estriol) are now being studied to see if excessive estrogen activity is associated with breast cancer.[35] Estriol, which is believed to be noncarcinogenic, impedes the carcinogenic action of the other two estrogens.[36] The lower the ratio of estriol to estradiol plus estrone, the higher the risk of breast cancer. The estrogen hypothesis is further strengthened by studies showing high estriol among oriental women. (To be continued)

References can be obtained by request from the Wisconsin Clinical Cancer Center.

—Richard Friedman, MD
Jane Harberg
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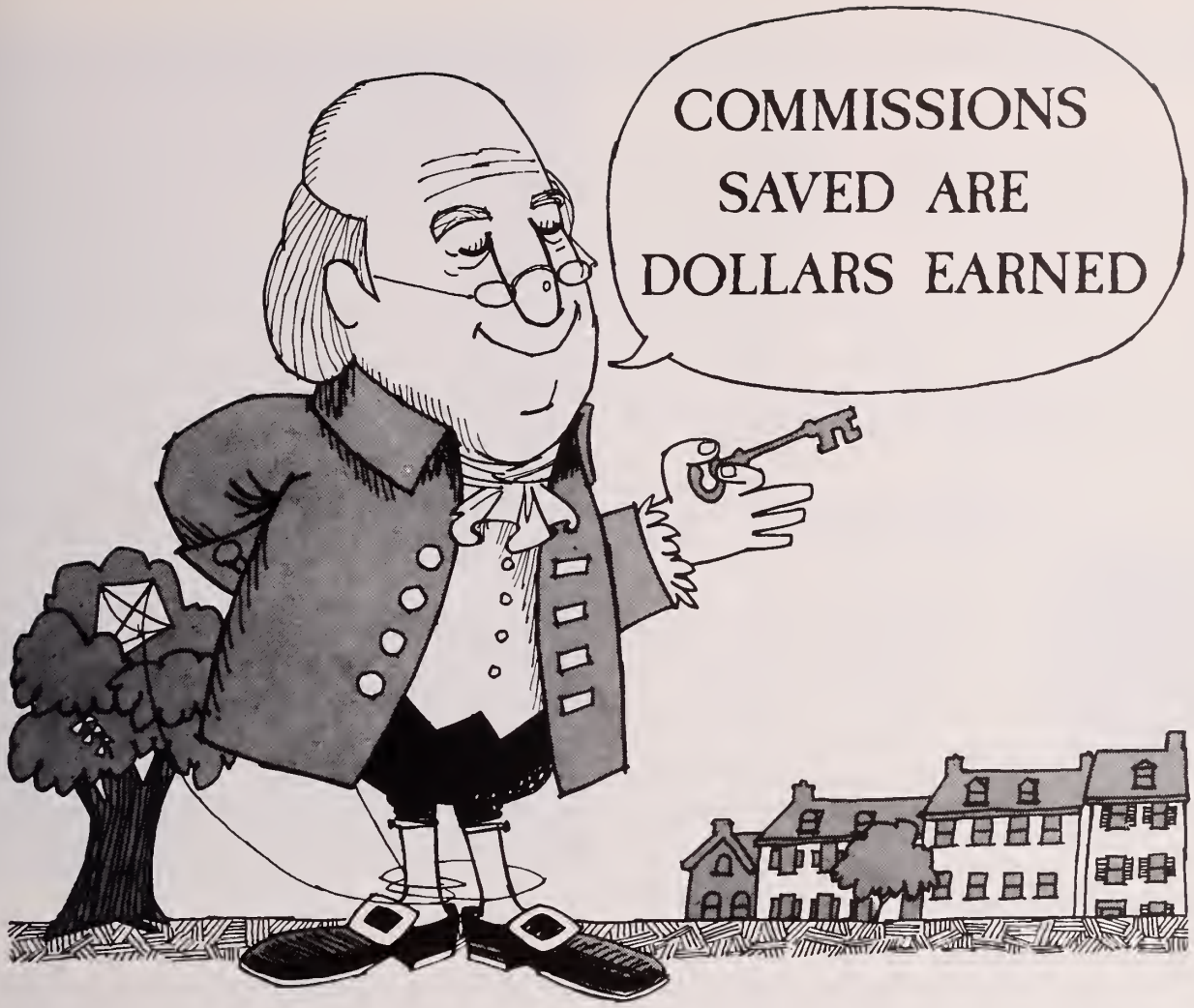

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THAT WAS A POPULAR chant throughout the late 1960s on many university campuses and, interestingly enough, also at least one hospital in California during the "malpractice crisis" in the early 1970s.

Where did that philosophy lead to and what effect did it have on the public attitude toward the medical profession? I would suggest that this attitude did little to enhance the standing of physicians and other health-care providers among the citizenry of this country. What then are the alternatives available to physicians in dealing with the public sector? One viable alternative was explored by a number of Physicians Alliance commissioners and staff at a negotiations seminar conducted by the AMA Department of Negotiations on March 17 and 18 at Oshkosh.

VISTE

In the two-day session, participants were exposed to negotiations techniques, strategies, and mock negotiating sessions. The program was rewarding and appropriate because whether or not physicians want to admit that "collective bargaining" is appropriate for their profession, it is rapidly becoming a way of life for physicians in dealing with state government. One need look only to the Legislature to see that it is already a common method of dealing with health issues before that body: certificate-of-need, brain death, optometric drug use, and so on. With respect to the bureaucracy, the current activity surrounding the medical assistance provider agreement and the "super-rule" has taken on overtones of a classic bargaining exercise.

With the creation of the Physicians Alliance in 1975, the State Medical Society wisely saw the need for the development of a negotiations arm. The March seminar was crucial in this effort, because for the first time it allowed *physicians* to be exposed to bargaining situations. This is important in that physicians need to understand the process by which Alliance staff reach agreements with other groups, and the Legislature, on health-care issues. It is only with that understanding and appreciation of the process that physicians will be able to fully support the efforts of the Alliance.

The seminar itself began with a series of lectures by the AMA staff on the techniques of negotiation, as well as an indication of the various "role models" that negotiators assume in their deliberations. The act of negotiating began with very simple and elementary exercises; teams of physicians and staff had to successfully negotiate for materials (paper, scissors, paper clips, etc) in order to "construct" end products, in this case paper link chains, colored pieces of paper, and the like. While this exercise seems basic, it was just that in order to familiarize the participants with the most basic skills needed.

Once the participants became familiar with these basic skills, we moved along to a mock negotiating session. This session involved two teams, one representing a state medical society and the other a state government agency responsible for the administration of a medical assistance program. The issue? Establishment of a T-19 provider contract and the terms of reimbursement in the program.

Ironically, this session was based upon an actual case history of negotiations between the state medical society and the state department of welfare in Utah. It was timely in that our Society and the Wisconsin Department of Health and Social Services are currently engaged in similar discussions. Because the participants were so familiar with the issues in this area, agreement was difficult; in fact one team managed to reach agreement on only one issue—the use of an annual contract!

While we were unable to reach total agreement in our session in the rather short time allowed for the negotiations, the exercise gave all of us an opportunity to know first hand what negotiators experience in such exercises. I am confident that all the participants came away from the seminar with a better understanding of what is necessary for bargaining to work for the benefit of both sides of an issue.

What is next? That question seems obvious because bargaining in health care is still in its infancy here in Wisconsin. However, one point stressed by the AMA staff at the seminar was that Wisconsin is much farther along than most state societies in dealing with governmental agencies from a negotiations perspective. The establishment of the Physicians Alliance sets the stage and lays the necessary groundwork for the continued expansion of our negotiations efforts. An obvious step for staff and participating physicians is exposure to more advanced negotiation training. For physicians generally the next step is an acceptance of negotiations as a standard procedure for dealing with government. Without that acceptance, all of medicine will suffer.

—KENNETH M VISTE JR, MD
Chairman, Physicians Alliance Commission
Oshkosh

The New President:

Jules D Levin, MD

DOCTOR JULES D LEVIN, Milwaukee neurological surgeon, became the State Medical Society of Wisconsin's 123rd President on April 15, during the Society's Annual Meeting in Milwaukee. He succeeds Roy B Larsen, MD of Wausau.

Born January 14, 1915 in Milwaukee, Doctor Levin graduated from the University of Wisconsin Medical School in 1938 and completed his internship at the University Hospitals, Madison, in 1939. He served an interim residency at the Johnston Emergency Hospital, Milwaukee, in 1939-41 and had a fellowship in neurology and neurological surgery at the University of Minnesota Hospitals in 1941-48, interrupted by two years as a Captain in the Medical Corps AUS. Doctor Levin was licensed to practice medicine in Wisconsin in 1939, was certified by the American Board of Neurological Surgery in 1951, and has practiced neurological surgery in Milwaukee since 1948.

Doctor Levin is an Associate Clinical Professor of Neurological Surgery at the Medical College of Wisconsin. He is on the medical staffs of the St Luke's, St Francis, West Allis Memorial, Deaconess, Mt Sinai Medical Center, St Michael's, and Milwaukee Children's hospitals and has been Chief of Neurosurgery at each of them. He is on the consulting staff of the Milwaukee County General Hospital.

He is a Fellow of the American College of Surgeons and of the International College of Surgeons, and a member of the American Association of Neurological Surgeons (Harvey Cushing Society), Congress of Neurological Surgeons, American Academy of Neurology, Association for Research in Nervous and Mental Disease, Central Neurosurgical Society, Pan American Medical Society, Pan Pacific Surgical Society, Royal Society of Medicine (London), Milwaukee Neuropsychiatric Society, Milwaukee Academy of Medicine, and the American Medical Association. He is a past President of the Medical Society of Milwaukee County and of the Milwaukee Neuropsychiatric Society.

At the present time, Doctor Levin is a member of the Governing Council of the Milwaukee Regional Medical Center, a member of the Board of Directors of the Foundation for Medical Care Evaluation of Southeastern Wisconsin (FMCE), Wisconsin Health Care Review, Inc (WHCRI), and the Milwaukee Rotary Club. Doctor Levin served on the Board of Trustees of the CES Foundation of the State Medical Society. He was past alternate delegate to the American Medical Association from the State Medical Society of Wisconsin and past delegate from the Medical Society of Milwaukee County to the State Society.

Doctor Levin is a 32nd degree Mason, a Shriner and a Rotarian.

His wife, Beverly, is a professional opera singer, who still performs for various civic and charitable organizations. Their three children, Ronald, Ellen, and Bruce, are all grown. ■

PRESIDENT LEVIN . . .

Education Communication Participation

I acknowledge with gratitude, and accept with humility the opportunity you have afforded me in being your president for the ensuing year. I wish to thank those of you who voted for me; and my wife, Beverly, wishes to thank all of you who voted against me! As physicians, we are proud of our professional heritage: we respect and admire those who have come before us, whose selfless dedicated and arduous labors created the excellence of modern medicine. The future of health care in this country and the future of our very profession, however, demands a new and critical evaluation and dedication.

I have chosen three key words as the guide lines for the coming year: *Education, Communication,* and *Participation.*

An aspect of *Education,* familiar to all physicians throughout their entire professional lives, is that of continuing medical education. This needs no further comment. The aspect of education about which I wish to comment, however, deals with social, civic, and political awareness at local, state, and national levels. I speak to the multitudes of governmental programs and legislation, together with their rules and regulations, regarding which most physicians have little or no awareness or knowledge.

To illustrate: Health Systems Agencies, and the health planning movement they represent, are probably the single most significant public-private development in health care in this country. They will decide whether, where, and how hospitals will be built and operated, who will have what equipment, who will use it, and for what purpose. By determining the location of the facilities, and the grouping of health personnel, they will tell patients where they will get their care and from whom. They will control all of the federal monies coming into their areas for health activities. They are rapidly assuming the characteristics of Him "who giveth and taketh away," in health care. Today, all of this is being done with a discouragingly minimum of professional medical advice. It is rather horrifying to know that, according to a recent State Medical Society poll, some 20% of the responding doctors in the State of Wisconsin do not know what the letters "HSA" represent!

We must have close relationships with our health-care colleagues, for of necessity we must work together to achieve the objectives of our profession: the well-being of the patient. But physicians must come to realize that equally as important in achieving our views of what is best for the health and well-being of every citizen is the understanding of labor, business, and the consumers. Their comprehension of good health and good medical care is absolutely essential to good health planning. *They* are the majority decision-makers on the HSA boards. *They* are the people pressing for peer review, for truthfully they *are* the "public" whom we serve. As your president in 1978-79, I will do my utmost to bring the physicians of this state

HSAs "are rapidly assuming the characteristics of Him 'who giveth and taketh away' in health care."

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and our Society into greater liaison with the public: the people in labor, in business, and in all walks of life. It is with these people we have our interest. They have the best and greatest appreciation for dedicated, quality medical care. They understand the problems of inflation. They empathize with us in our frustrations with the bureaucracy.

Despite the current high-confidence polls enjoyed by physicians, we *must* believe that the rapidly increasing harassment of doctors by government officials and the bureaucracies, via the media, must and will take its toll. Consider only the matter of physicians' fees: the recent wage council report from President Carter's office was filled with obvious distortions and misrepresentations, and only one radio station reporter of all the media in Wisconsin even bothered to ask the State Medical Society whether it had any comment!

"PSROs are far more than patient care length of stay. They are mandated to advise the HSAs on the latters' five-year health plans and annual implementation plans. They are considering moving into areas of medical education and discipline. Their once highly touted commitment to confidentiality of information is breaking down . . ."

PSRO (Professional Standards Review Organization) has been with us now for some five years. Let us briefly consider the implications of the PSRO activities upon the county, state, national, and specialty societies. The PSRO is a physician membership organization without personal member dues. The costs are borne by all taxpayers. The PSROs are into far more than patient care length of stay. They are prohibited from having medical society representatives on their boards or district review councils. They are prohibited from employment relationships with medical societies, under the guise of conflict of interest. They are mandated to advise the HSAs on the latters' five-year health plans and annual implementation plans. They are considering moving into areas of medical education and discipline. Their once highly touted commitment to confidentiality of information is breaking down, first by a recent HEW order to release hospital-specific uniform discharge data (by name of hospital and diagnosis) to health planners, governmental agencies, and literally anybody who asks. Equally recently, HEW has informed the PSROs that they *shall* provide all specific data they may have on any doctor when some state or federal agency asks for it in connection with "fraud and abuse" investigations; and if the PSRO considers the information as indicating "fraud or abuse." But a more recent HEW communique reminds the PSROs that their considerations are only "advisory;" hence the government, once in possession of information, may well override the opinion of the PSRO. Knowing the propensity of several state and federal agencies to abuse the interpretation of medical "abuse," such developments should strengthen our efforts to assure at least some realistic degree of due process. The handwriting is on the wall: unless the medical profession resists, the federal government is rapidly moving the PSROs into the position where they will be the new every-doctor-no-dues medical society in the emerging national health system.

Our second key-word is *Communication:* Unfortunately, despite our education and sophistication, physicians notoriously communicate rather poorly. Whether this is because of lack of time or lack of interest is not important. Harry Schwartz, in his book, "The Case for American Medicine," appraised the situation correctly when he said, "Doctors speak only to each other and to God, ... that is, if God has an appointment!" Communication implies a will to speak and the ability to speak, a will to listen and the ability to listen. Many physicians have the abilities, but unfortunately either lack the initiative or are unable to correlate them effectively. Some of us do not speak when we should be speaking, many of us are not listening when we should be listening. We have writers and speakers, we have journals and meetings, we have

"The handwriting is on the wall: unless the medical profession resists, the federal government is rapidly moving the PSROs into the position where they will be the new every-doctor-no-dues medical society in the emerging national health system."

readers and members, but too few read, listen, and speak. To date, neither the threat of federal bureaucracy nor the specter of socialized medicine has moved us to communicate. And what is it that we must communicate? The current information regarding the multitudes of legislative statutes relating to medicine, the knowledgeable and intelligent evaluation of programs, rules and regulations regarding health-care delivery. We must discuss our ideas with our health-care colleagues as well as with the public; we must be a source of information to our legislators and the public policymaking committees. We must help to formulate the direction of health-care delivery. To accomplish this we must take the time to read the reams of reports and edicts promulgated by our esoteric economists and social workers. We must disseminate this information to all the physicians in the state, and must gather the attitudes and opinions, to form a consensus, and thus respond to the challenges in medical care. Ladies and Gentlemen, the hour is late: unless we effectively communicate our needs, desires, and knowledge we shall quickly be muted.

"We must discuss our ideas with our health-care colleagues as well as the public; we must be a source of information to our legislators and the pubic policy-making committees. We must help to formulate the direction of health-care delivery."

"Physicians must change their attitudes and rearrange their priorities. It is no longer tenable to merely practice medicine well."

Our final key word is *Participation*. More and more physicians are finally realizing that their allegiance and loyalty is first to the Medical Society and their colleagues, rather than to the individual hospital staff. Hospitals are indeed our health-care colleagues, but they are independent institutions with many priorities of their own, many of which do not coincide with the priorities of the individual physician. The admonition of Hillel, the Sage of Old, rings loud and clear: "If we are not for ourselves, then who is for us?" I urge you to join with your colleagues, for one man alone can accomplish but little: one voice is but a plea. But together we can create a formidable impact. Your active participation is direly needed, both physically and financially. We can no longer afford the luxury of passive observers, who reap all the benefits yet are riding free. You can no longer default because of displeasure with one worker or one cause. You cannot take your glove and go home. You must play ball. YOU ARE YOUR BROTHER'S KEEPER!

The way of politics is many times devious. We must offer the challenge, yet keep our eye on the ultimate goal, but learn to compromise. If politics is the way of life, and the way of the market place, then we must be in the market place, ready to participate.

Our medical societies are gradually changing, albeit slowly, to meet these new challenges. Our membership polls are giant steps forward in communication with the individual physician.

"The way of politics is many times devious. We must offer the challenge, yet keep our eye on the ultimate goal, but learn to compromise. If politics is the way of life, and the way of the market place, then we must be in the market place, ready to participate."

Our Physicians Alliance has made great strides in initiating local activities to understand and become part of the political process. I will do all in my power to continue these changes and to increase the impetus. We are living through the era of what historians may well call "the medical reformation." We will not be educated until we are educated for all the capricious and unexpected emergencies and emotions of the erst while social reformers. Physicians must change their attitudes and rearrange their priorities. It is no longer tenable to merely practice medicine well. If we are to continue to serve humanity with medical care of constantly improving excellence, we must become knowledgeable, conversant, and active in all elements of the social and political environment, and its ever-changing climate. We must learn to communicate with all elements of society, and above all we must participate! ■

PAST PRESIDENT LARSEN . . .

An equal place in policy and planning

It seems appropriate to begin this report to the House of Delegates with the final paragraph of the address I made to you one year ago at the time of assuming the presidency of the State Medical Society. My closing remarks were as follows:

"There is much we must accomplish during the years ahead. If we act in a spirit of unity, marked only by honest diversions of opinion, I believe that we can discharge our duties as citizens for the general good of all. Surely the most sophisticated mechanism for the delivery of health care must fail, if participating physicians are not available to render such care. As providers of care, we seek an equal place in policy and planning necessary to ensure the quality of medical service. I would ask all members of this Society to join their energies toward realization of this, our common goal."

Our primary concerns are related to quality health care, containment of cost, and access to health services. We have a second important responsibility in disease prevention and control, particularly in the highly visible field of immunization.

Unfortunately, while we are generally blamed for the ill health of much of the population, some solutions lie far beyond our control. The medical community alone cannot solve the problems of poverty, pollution, malnutrition, unemployment, discrimination or trashing the body with booze, chemicals, and tobacco.

First, I would like to share a brief look at health in the United States as reported by the Secretary of Health, Education, and Welfare to the Congress of the United States. This report provides detailed information on health-care costs and financing, health services availability and utilization, and health status in the United States.

Following this, we will review briefly what the State Medical Society of Wisconsin has done, and anticipates doing, to cope with our problems.

Health-care expenditures totaled $12 billion in 1950 and represented 4.5 percent of the Gross National Product. In 1976, total expenditures were 139.3 billion, 8.6 percent of the Gross National Product. Physician's services now account for 19 percent of total health expenditures in contrast to 22 percent in 1960, dentist's services declined from 8 percent to 6 percent and drugs from 14 percent to 8 percent. By contrast, in the same period, hospital care rose from 31 percent of total health-care spending to 40 percent of the total, and nursing home care from 6 percent of the total in *1970* to 8 percent in 1976.

Physicians have a direct role in ordering hospital and nursing home services. However, the main factors in rising hospital and nursing home costs are the growth and aging of the population, increased cost of labor and supplies, increased demand with the growth of private health insurance and government programs, and costly technological changes.

"Our primary concerns are related to quality health care, containment of cost, and access to health services."

The amount of money spent in health care increases sharply with age. Currently, those age 65 and over total 10 percent of the population. Per capita expenditures for the elderly in 1976 were almost three times higher than that for persons 19 to 64 years of age, and more than six times higher than that for persons under the age

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of 19. Government spending on personal health care—hospitalization, physician's and dentist's services, drugs, and other services and supplies provided to individuals—totaled $120.4 billion in the year ending June 30, 1976. This constituted 86 percent of total health expenditures. Government and private health insurance paid 66 percent of the outlay for personal health care with direct payments by patients accounting for 33 percent and a mere 1 percent covered by philanthropy and industry.

Third parties continue to pay a growing share of the personal health-care bill. The government's share has increased from 20 percent in 1950 to 40 percent in 1976. Private health insurance programs grew from a 9 percent portion of personal health expenditures in 1950 to a 26 percent portion in 1976. Dramatic expansion of the government portion closely followed the passage of Medicare and Medicaid programs in 1965.

"Physician's services now account for 19 percent of total health expenditures in contrast to 22 percent in 1960."

Campaign speeches by President Carter promised a national health bill. Increasingly, there seems much less clamor for a total federal health bill because of the anticipated staggering costs. If we are to use the Medicare and Medicaid programs as examples, and approach total federal financing of some type for health care, it is highly probable that health expenditures would surpass that of the entire defense department. Inevitably, the likelihood of some federal legislation is good but will probably initially be restricted to catastrophic care and provisions for certain classes of the medically indigents. The administration has proposed a ceiling of 9 percent on hospital care cost increases, while the American Medical Association, the American Hospital Association, and the Federation of American Hospitals, have produced a plan for voluntary controls. Congressman Rostenkowski has proposed legislation calling for such voluntary controls with standby measures which would take effect if voluntary controls fail.

"The Physicians Alliance has acquitted itself well in the public area and deserves our united support in the future."

The National Commission on the Cost of Medical Care presented a report in December 1977 with 48 specific recommendations. You have all received an analysis of this report by the State Medical Society Committee on Evaluation of the Delivery and Cost of Medical Care together with its comments and recommendations. Careful reading of this document is essential for each of us if we are to understand and assist the medical community in an effort to control the cost of care while still retaining the quality of care.

It is my strong impression that the State Medical Society has made great progress on many fronts during the past year. This is not an accident but is a result of organized efforts by the medical community enabling us to have a significant impact upon many important issues. I would like to mention a few of these in brief:

Wisconsin Health Care Liability Insurance Plan

The Supreme Court has upheld the panel system authorized by this legislation. Administration of the plan continues to be successful and has resulted in a 15 percent reduction in premiums payable during the past year as well as a 50 percent reduction in umbrella coverage.

Fee freeze suit

The fee freeze imposed by then Governor Lucey on December 23, 1974, remained effective until May 2, 1977, when an injunction sought by the State Medical Society ended the freeze by order of Judge P Charles Jones.

Membership

Our membership drive during the past year has not been an unqualified success but has exhibited bright spots in that we have welcomed many faculty members of our two medical schools to the Society. I hope that we attract an increasing number in the future to insure a proper balance of thought and action between these physicians and their colleagues in clinical practice. There has been an encouraging rise and interest in the numbers of medical students and residents involved in medical society activities and they have been offered an increasing voice and responsibility, preparing them for leadership roles in the years ahead.

Certificate-of-need legislation

Our legislative representatives played a skillful and important role in the passage of this legislation mandated under Public Law 93-641. Without the input from the State Medical Society, the effects upon us as a profession could have been disastrous.

State Medical Society—WPSIC

One of the most vexatious and time-consuming problems during the past year has been the mandated separation of the Society and WPS. This House will be asked to act on proposals concerning our present relationship to WPS. Our sole remaining connection at the present time is that the Council of the State Medical Society constitutes the membership of WPS and, therefore, nominates the members of the 30-member board in control of WPS. This situation is to be debated and hopefully resolved at this session.

Physicians Alliance

There have been criticisms during the past year that the Physicians Alliance constitutes a parallel medical society. The Alliance has been extremely effective in a multitude of legislative matters that have come before it and has exercised a strong arm in the local political arena. It is to be emphasized that it is not duplicating efforts of the Society in that it has no function in peer review, continuing medical education, medical ethics, evaluation of the cost and delivery of medical care, or in the various committee activities which exist within the Society. The Alliance has acquitted itself well in the public area and deserves our united support in the future. I need to mention only one instance, that of the acting Governor's veto of Senate Bill 108 (mandated insurance for chiropractic) with the Senate then upholding the veto. The Senate vote to sustain the veto was not an accident but was the result and culmination of strenuous effort on the part of many, many physicians working with the staff of the Physicians Alliance.

Peer review

The complexities of peer review have been addressed for the past six months by the Council of the State Medical Society and all members of this House have received voluminous reports on the progress made to date. It would be easy to spend the next few pages detailing the possible solutions to the problems of private and federally mandated peer review. However, adequate debate on these measures will be afforded and further recommendations will be forthcoming from the Council for deliberation by this body.

Department of Health and Social Services

You are all familiar with the charges made in September 1977 by the then Chief of the Health Department concerning alleged unnecessary surgery in Wisconsin which he claimed totaled 77,000 cases at a cost of 80 million dollars. These statements were promptly challenged by the Medical Society and as of this time, we are working closely in a joint committee with representatives from the State Medical Society and appointees from the Department of Health and Social Services to sift the statistics and report on the Wisconsin situation.

The demands of various departments of the state government place increasingly burdensome tasks on the Medical Society. Currently, the Society is in the midst of attempting a response to contradictory requests from two arms of state government. The Department of Health and Social Services, acting under state law, is implementing a contract with individual physicians. The Department has called upon the Society to negotiate the terms and conditions, including rates, of physician reimbursement under Medicaid. This request is designed to replace the use of Medicaid profiles as the basis of physician reimbursement by Medicaid. At the same time, E.D.S. has requested that the Society give its approval to the use of the 1964 California Relative Value Schedule as the principal base for reimbursement under Medicaid.

"The demands of various departments of the state government place increasingly burdensome tasks on the Medical Society."

The requests from the Department of Health and Social Services have been utterly complicated by a letter from the Attorney General's office to the Society, and to all county medical societies, asking for voluntary submission of information related to investigation by that office of medical organizations, including the use of

relative value guides and conversion factors. We can only assume that the investigation may be the first step to charges of price fixing and restraint of trade. Currently the Society is seeking more information on these contradictory requests and in the words of our secretary, Earl Thayer, it appears "that the Society is damned if it does and damned if it doesn't" comply with all requests!

A two-day meeting in Wausau in September 1977 was devoted entirely to outlining the problems of the State Medical Society and proposing solutions to these problems. Active participants were all of the members of the Council, chairmen of major committees and the delegates and alternate delegates to the American Medical Association. The results of this conference have been further analyzed by the Council and specific recommendations have been made for implementation. Goals for 1978 include continued physician involvement in health planning and cost containment issues, increased communication with physician membership, increasing the availability of quality continuing medical education programs plus a host of other activities including efforts through the media to better outline our role in health matters, continuation of legislative efforts with organized lobbying during legislative sessions and an increasing effort toward recruitment of members to the Society.

This address cannot be concluded without specific recognition of the extensive contributions in time and expertise given by the officers, members of the Council, and the hard-working commissions and committees. We also owe a special thanks to a superb staff organization which has responded to and even have anticipated the wishes, desires, and goals of the membership. It has been an eventful year and I thank the members of this House for allowing me to participate. ■

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Council adopts position on physician advertising

At its April 12 meeting in Milwaukee the SMS Council adopted an official position on physician advertising which reads:

"The State Medical Society of Wisconsin does not have a policy prohibiting advertising by physicians excepting that such advertising may not contain information that is false, misleading or deceptive. The American Medical Association has issued guidelines on 'Advertising and Solicitation' which might be useful in helping physicians determine the appropriateness of advertising plans. These guidelines are not to be interpreted as rules or regulations of the State Medical Society of Wisconsin, but are for informational and guidance purposes only."

Copies of the AMA guidelines are available from the Communications Department at SMS offices in Madison (PO Box 1109, Madison Wis 53701) or phone toll-free: 1-800-362-9080. ■

School lunchroom position adopted by SMS Council

The SMS Council at its April 12 meeting in Milwaukee adopted a position statement recommended by the SMS Committee on School Health which opposes the sale and distribution of confections and soft drinks in school lunchrooms.

Copies of the statement may be obtained by contacting the SMS Communications Department in Madison (PO Box 1109, Madison, Wis 53701) or phone toll-free: 1-800-362-9080. ■

Doctors Viste and Frank reelected PAC officers

The Physicians Alliance Commission at its April 21 meeting reelected Kenneth M Viste Jr, MD, Oshkosh, chairman of the Commission, and Jordon Frank, MD, Beloit, vice-chairman. ■

New Physicians Alliance lobbyists named

Physicians Alliance field consultants Michael Brozek of New London and Mark Mendelson of River Falls have been selected as legislative coordinators for the SMS Physicians Alliance Division.

Brozek and Mendelson replace Brian Jensen and Doug Nelson. Jensen is now director of the SMS Physicians Alliance Division and Nelson recently was named director of the Quality Care Division of SMS. ■

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Dr Haskins reelected Council chairman

The Council reelected Paul S Haskins, MD of River Falls as its chairman for the ensuing year. The Council also elected Timothy T Flaherty, MD of Neenah as its vice-chairman.

Eugene J Nordby, MD of Madison was reelected treasurer; Earl R Thayer of Madison, secretary; Abraham A Quisling, MD and H Kent Tenney, MD of Madison, assistant treasurers.

The above elections and others made by the Council and the House of Delegates at the Annual Meeting, April 13-15, in Milwaukee appear elsewhere in this issue. ■

Council votes to reopen Museum

After being closed last year, the Fort Crawford Military Hospital at the Museum of Medical Progress in Prairie du Chien was reopened May 1.

At its April 12 meeting in Milwaukee the SMS Council gave temporary funding to its Charitable, Educational and Scientific Foundation (CESF) to reopen the Museum for the 1978 season.

The Museum, which is owned and operated by CESF, was closed in April 1977 because the CESF Board of Trustees was unable to fund the Museum's operating losses.

The Council also directed the staff to draft plans for a fund-raising program to create an endowment fund which would cover the Museum's operating expenses in the future.

The Museum, located at 717 Beaumont Road, is open now through Labor Day (September 4), from 12:00 pm until 6:00 pm, Wednesday through Sunday. ■

Elections: House of Delegates, Council

The House of Delegates elected (or reelected) the following physicians to these positions:

PRESIDENT-ELECT:
Darold A Treffert, MD, Winnebago

VICE-SPEAKER:
Duane W Taebel, MD, LaCrosse

AMA DELEGATES (1979-1980):
DeLore Williams, MD, West Allis
Patricia J Stuff, MD, Bonduel
John K Scott, MD, Madison

AMA ALTERNATE DELEGATES (1979-1980):
John D Riesch, MD, Menomonee Falls
Cornelius A Natoli, MD, LaCrosse
Richard W Edwards, MD, Richland Center

AMA ALTERNATE DELEGATE (1978-1979):
Warren H Williamson, MD, Racine

AMA ALTERNATE DELEGATE (1979):
John R McKenzie, Jr, MD, Oshkosh

Attendance: 1,418

Total attendance of the two-day scientific program, April 14-15, at the MECCA in Milwaukee was 1,418.

Registration of physician members was 933, while the balance consisted of 27 non-member physician registrants; 39 physician guests; 106 technical exhibitors; 35 scientific exhibitors; 101 interns, residents, and medical students; and 177 guests (certified nurses, physician spouses, etc).

The three sessions of the House of Delegates had the following registrations: 130 first session; 134, second session; and 108, third session. There are 152 voting members of the House. ■

COUNCILORS:
District 1 (reelected)
Wayne J Boulanger, MD, Milwaukee
Daniel K Schmidt, MD, Milwaukee
John J Foley, MD, Menomonee Falls
Irwin J Bruhn, MD, Walworth
Elizabeth A Steffen, MD, Racine
William A Nielsen, MD, West Bend

District 2 (reelected)
William P Crowley, Jr, MD, Madison

District 8 (elected)
Joseph M Jauquet, MD, Ashland

The Council elected (or reelected) the following physicians to these positions:

CHAIRMAN OF THE COUNCIL:
Paul S Haskins, MD, River Falls

COUNCIL VICE-CHAIRMAN:
Timothy T Flaherty, MD, Neenah

SECRETARY AND GENERAL MANAGER OF THE SOCIETY:
Earl R Thayer, Madison

TREASURER OF THE SOCIETY:
Eugene J Nordby, MD, Madison

ASSISTANT TREASURERS:
Abraham A Quisling, MD, Madison
H Kent Tenney, MD, Madison

WISCONSIN MEDICAL JOURNAL:
Medical Editor (two-year term)
Victor S Falk, Jr, MD, Edgerton
Editorial Director
Wayne J Boulanger, MD, Milwaukee
Editorial Associates
John P Mullooly, MD, Milwaukee
Brenton H Field, Jr, MD, Milwaukee
T H McDonell, MD, Waukesha
Philip J Dougherty, MD, Menomonee Falls
Raymond A McCormick, MD, Green Bay

A full list of appointments to commissions of the Society will appear in next month's BLUE BOOK issue of the *Wisconsin Medical Journal*. That issue will contain a complete listing of all Society officers and commission/committee members. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.14 as of March 31, 1978. ■

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Summary Report, House of Delegates

State Medical Society of Wisconsin, April 13-15, 1978, Milwaukee

THE FOLLOWING constitutes the summary report of actions taken at the Annual Session of the House of Delegates, April 13-15, 1978, replacing the formal printing of reports and detailed proceedings because of the great expense involved. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the content of a particular report or resolution.

Earl R Thayer
Secretary

THE HOUSE DELIBERATED 41 resolutions submitted by county medical societies, specialty sections, and a councilor district delegation, as well as reports of officers, the Council, commissions and committees of the Society. Refer to the March 1978 *Wisconsin Medical Journal* for abstracts of the resolutions and their sources. Following is the text of the House of Delegates reference committee reports (with additional text inserted where needed for meaning) and indication of action upon their recommendations by the House.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

● RESOLUTIONS 1, 2, 3, 4, and 5—*Unified Membership.* With reference to resolutions 1 through 5 dealing with unified membership, the committee heard overwhelming testimony against termination of unified membership and against conducting a referendum [pursuant to Article XI] for action by the House. It was the strong consensus of those who spoke at the hearing that resolutions 4 and 5 [to end AMA membership requirement or discontinue unified membership rule] be rejected and the committee concurs. Based on legal opinion that a referendum can be only informational and not binding on the House, the committee recommends rejection of resolutions 1, 2 and 3 [proposing a binding referendum on amending the Constitution]. The committee offers the following *legal opinion* for clarification of the action:

> In our opinion the Society Constitution can be amended only by the House of Delegates and only in the manner prescribed by Article XIII. It is our further opinion that a referendum on a possible or proposed constitutional amendment submitted to the general membership has no legal effect because the manner of amendment is determined by the Constitution itself. Such a referendum would, therefore, not even be advisory in nature since it is not the authorized way in which the House is mandated by the Constitution to consider and adopt amendments of that document.
>
> We find no conflict between Articles XI and XIII. Article XI might govern constitutional amendments except for the presence of Article XIII. Article XI is general. Article XIII is specific, and is limited to the subject of constitutional amendments. Article XIII is also later in position than Article XI. Under basic rules of documentary construction a specific provision governs general wording and text later in position governs that earlier in position.

Your committee recommends rejection of resolutions 1, 2, 3, 4, and 5. ¶Action: RESOLUTIONS REJECTED

● RESOLUTION 20—*Insurance Company Influences on Medical Practice Trends* [*eg.* publishing lists of "non-pay" operations]. The committee believes it is not within the power of the State Medical Society to interfere with an insurance company's prerogatives; however, it recommends that the Society go on record as encouraging insurance companies to consult with medical societies on appropriate procedures. Therefore, the committee recommends rejection of resolution 20.

¶Action: RESOLUTION REJECTED

● RESOLUTION 21—*Equal Payment Policies by Insurance Companies.* The committee recommends that space requirements should be incorporated in the physician's fee and therefore recommends adoption of the resolution with deletion of the phrase "and for the space required to perform those services," the resolve then to read: "That the State Medical Society of Wisconsin advocates an 'equal payment policy' by insurance companies to guarantee that services rendered in the physician's office will be paid for on the same basis as they would be in the hospital, including payment for the physician's service [and] any supplies required." ¶Action: RESOLUTION ADOPTED AS AMENDED AND REFERRED TO THE COUNCIL FOR IMPLEMENTATION.

● RESOLUTION 22—*Free Choice of Physician.* The committee took no action on the resolution since it was withdrawn by a representative of the sponsor following clarification of the issue by representatives of the Dane County Health Maintenance Program.

¶Action: NONE; WITHDRAWN

● RESOLUTION 24—*Doctor-Patient Relationship.* The committee recommends rejection of the resolution [calling for attempts to rescind current rules and regulations and oppose future rules and regulations that interfere with the doctor-patient relationship] on the basis that its proposals are too broad and unworkable and that there are existing committees of the State Medical Society currently carrying out the spirit of this resolution.

¶Action: RESOLUTION REJECTED

● RESOLUTION 25—*Physicians' Office Records.* The committee recommends adoption of this resolution keeping in mind the excellent work of the Physicians Alliance. [Resolution 25 requests the Society to apprise its members of the successful battle against HEW invasion of doctors' offices in California to inspect Medicaid records; further that it "keep its ear tuned to this threat and have ready a legal plan of action" against violation of Wisconsin physicians' offices by federal or state agents.]

¶Action: ADOPTED

● RESOLUTION 32—*Housestaff Contracts.* The committee recommends adoption since the AMA already has Housestaff Guidelines; and further recommends implementation of these Guidelines by the State Medical Society, [communicating this policy to all institutions or hospitals in Wisconsin with housestaff training programs.]

¶Action: ADOPTED

● RESOLUTION 33—*Emergency Treatment Follow-up.* The committee recommends adoption of this resolution reversing the order of the resolve to read: "That every effort be made at the time of the emergency to contact the private physician and notify him of the situation, and that emergency departments be ~~[required]~~ *encouraged* to send a report to the patient's private physician for follow-up of all emergency treatment the day after the visit."

¶Action: ADOPTED AS AMENDED

● RESOLUTION 34—*Hospital Bed Access.* The committee recommends rejection of this resolution in the belief that this is a local situation and should be handled by local health planners and medical staffs. The committee further recommends that emphasis be directed to health planners on the dangers of inadequate numbers of hospital beds to current as well as future physicians.

¶Action: RESOLUTION REJECTED

● RESOLUTION 35—*Physical Therapy Programs Accreditation.* The committee recommends adoption of this resolution supporting the AMA Committee on Allied Health Education and Accreditation—Physical Therapy Review Committee.

¶Action: ADOPTED

● RESOLUTION 40—*County Medical Society Meetings.* The committee recommends rejection of this resolution [urging frequent membership meetings of every county society, with State Society staff assistance and reporting highlights from minutes to all other societies] with acknowledgement that while the proposals are good, they lack a fiscal note. The committee further recommends that county medical society meetings be encouraged and that their minutes be forwarded to the State Medical Society.

¶Action: RESOLUTION REJECTED

● RESOLUTION 41—*AMA Presidency.* The committee recommends adoption of this resolution "that the State Medical Society formalize its position that the AMA President be elected by the House of Delegates for an appropriate but temporary term, and that a continuing effort be made within AMA to strengthen the role of its President."

¶Action: ADOPTED

COUNCIL AWARD

Ben R Lawton, MD

The highest honor of the State Medical Society, the Council Award, was presented to Ben R Lawton, MD of Marshfield April 14 at the Presidents' dinner at the Society's Annual Meeting in Milwaukee. In presenting the award, Paul S Haskins, MD, River Falls, Chairman of the Council, said Doctor Lawton "has proven himself a true leader for the medical profession and all Wisconsin citizens." Doctor Lawton's award marked the 42nd time the honor has been bestowed to a physician who "personifies the highest ideals in his devotion to the public good."

Currently chairman of the State Health Policy Council, Doctor Lawton has guided Wisconsin to a nationally recognized position in comprehensive health planning. For six years he served as president of the Marshfield Clinic, and under his leadership the Clinic established one of the nation's first health maintenance type organizations with substantial rural coverage. For many years Doctor Lawton has served on the Clinic's executive committee.

Doctor Lawton was appointed by Governor Patrick Lucey to the University of Wisconsin Board of Regents in 1976. Governor Lucey, in announcing the appointment, said: "Throughout his years of professional life, Doctor Lawton has earned a reputation for practicing a brand of socially conscious, progressive medicine that considers the needs of rural and urban family alike."

A graduate of the University of Wisconsin Medical School, Doctor Lawton served as a clinical professor at the school from 1972 to 1976 and was president of the University of Wisconsin Medical Alumni Association from 1961 to 1962. He is a past president of the Wisconsin Surgical Society and was vice-chairman of the Governor's Health Planning and Policy Task Force in 1971 to 1972. He became a member of the Institute of Medicine of the National Academy of Sciences in 1977.

Specializing in cardiovascular and thoracic surgery, Doctor Lawton served his internship at the University of Colorado in Denver, and his residency at Lutheran Hospital in LaCrosse and Wisconsin General Hospital in Madison. For two years he headed the thoracic surgery department at the US Army Valley Forge Hospital.

● Council Report T, Part 8 and Exhibits B and C. The committee recommends adoption of two amendments to the Society's Bylaws, relating to (1) the definition of qualifications for membership, and (2) eligibility for membership on Society commissions and committees.
¶Action: BYLAW AMENDMENTS ADOPTED and will be incorporated in next printing of Constitution and Bylaws in June 1978 *Wisconsin Medical Journal.*

● Report G—*Physicians Alliance Commission.* The committee recommends acceptance of Report G with particular commendation of the Commission's outstanding work during the past year. [The report summarized activities relating to physician opinion surveys; negotiations re Title XIX reimbursement, contract and "Super-Rule"; legislative contact system and local alliance organizations; also the status of the professional liability legislative package, medical defense committee work, and progress on a uniform claim form and coding.] ¶Action: ACCEPTED

● Resolution 19—*Current Procedural Terminology IV.* This resolution was referred to this committee because of its relativity to Report G of the PAC. The committee recommends adoption of resolution 19 with changes in the resolve clause as follow: change the word "singular" to "exclusive" and add the words "and nomenclature" following "coding method." Therefore, the amended resolve is "that CPT IV be adopted by the State Medical Society of Wisconsin as the exclusive numerical insurance coding method and nomenclature and be supported with all third party carrier negotiations and discussions."
¶Action: ADOPTED AS AMENDED

● Report P—*Committee on Safe Transportation.* The committee recommends acceptance of Report P, including the "Physician Guidelines: Blood-Alcohol Testing 1978." The committee acknowledges that implementation of these Guidelines is still evolving and that attention be paid to Society publications for further changes in the interpretations as they develop. The committee also wishes to commend Doctor Weygandt and his committee for their diligent and comprehensive attention to the Guidelines as they continue to be updated. ¶Action: ACCEPTED

● Report Q—*Committee on Aging and Extended Care Facilities.* The committee recommends acceptance of Report Q as presented. [In reference to charges made by the Department of Health and Social Services regarding the relative frequency of lack of timely physician visits to nursing home patients, the committee report recommended that the House of Delegates vigorously advocate a program of physician recruitment and encouragement to visit nursing home patients, combined with a program of strengthening the responsibility of the medical director, if the DHSS can be persuaded to (1) tighten administrative guidelines to decrease unnecessary paper work and telephone communication; (2) establish equitable reimbursement rates for single and multiple patient visits; (3) establish a program of prompt reimbursement: (4) clarify and mandate patient and third party responsibility to pay for (non-patient) required visits; and (5) elaborate the policy that the medical director is required to see those patients not seen at appropriate intervals by the attending physician, but that this visitation in no way interferes with the rights and privileges of patient relationships to his attending physician.] ¶Action: ACCEPTED

● Supplementary report of council, item 1. The committee concurs with the Council's recommendation to create a nonresident membership category in the Bylaws by amending Chapter I to add a new Section 14, and a necessary editorial amendment in Chapter I, Section 5.
¶Action: BYLAW AMENDMENTS ADOPTED and will be incorporated in next printing of Constitution and Bylaws in June 1978 *Wisconsin Medical Journal.*

● Supplementary report of council, item 4. The committee recommends acceptance of item 4 pertaining to the Medicaid contract with particular attention to the final paragraph which recommends that the Council urge "the Society's Physicians Alliance Commission, staff and legal counsel to continue to negotiate for the best possible contract and Super Rule. The membership will be informed

ELVEHJEM MEMORIAL LECTURE AWARD

Kevin Parent, MD

Established in 1962 to honor the memory of Doctor Conrad A Elvehjem, the 13th President of the University of Wisconsin and an international authority in biochemistry, the Elvehjem Memorial Lecture Award was presented to Kevin Parent, MD, Marshfield, Wisconsin at the Internal Medicine plenary session at the Annual Meeting of the State Medical Society of Wisconsin. Doctor Parent, in the Department of Internal Medicine at the Marshfield Clinic, presented: "The Pathogenesis of Crohn's Disease: A Transmissable Infectious Agent" at the lecture sponsored by the Society's Charitable, Educational and Scientific Foundation (CESF). Presenting the award was John P Mullooly, MD, Milwaukee, a Councilor and member of the Board of Trustees of the CESF.

BEAUMONT MEMORIAL LECTURE AWARD

David B Skinner, MD

David B Skinner, MD, Chicago, Illinois received the 1978 Beaumont Memorial Lecture Award for his Annual Meeting presentation: "Management of Reflux Esophagitis." Doctor Skinner, Professor and Chairman of the Department of Surgery at the University of Chicago, gave his lecture at the scientific plenary surgery session in Milwaukee April 15. The award is given yearly to a distinguished surgeon. The William Beaumont Memorial Lecture Award was established in 1957 by the State Medical Society Council in honor of Doctor William Beaumont, a United States Army surgeon, who in the early 1800s performed a series of experiments which laid the foundation of our knowledge of digestion. Doctor Werner Langheim of Madison presented the award plaque to Doctor Skinner.

of the results in a timely fashion. *In the final analysis, the decision to sign or not to sign is that of the individual physician."* ¶Action: ACCEPTED

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● REPORT OF THE PRESIDENT. The committee recommends acceptance of the report of President Larsen reviewing accomplishments of the past year. [The full text appears elsewhere in this issue.] ¶Action: ACCEPTED

● REPORT OF THE PRESIDENT-ELECT. The committee recommends acceptance of the report of President-elect Levin on the theme of education-communication-participation. [The full text appears elsewhere in this issue.] ¶Action: ACCEPTED

● REPORT OF THE SECRETARY. The committee recommends filing the written report of the Secretary [on headquarters operations in responding to members' needs] and commendation of his oral report to the House at the first session [speaking to the issue of accusations of fraud and abuse by physicians, and countering with illustrations of "fraud and abuse" on the part of government in its activities.]

● REPORT A—*Commission on Peer Review*. The committee recommends this informational report be filed. [It includes discussion of activities involving peer review of Title XVIII referrals from WPS, fee review for insurance carriers, development of a protocol for Nursing Home Ombudsman referrals, and the matter of reimbursement for peer review services on which a recommendation will be submitted to the Council.] ¶Action: REPORT FILED

● REPORT H—*Wisconsin Medical Journal* EDITORIAL BOARD. The committee recommends this report be filed [which includes information on scientific articles submitted, accepted and rejected; also on financial aspects and the favorable outlook for increased advertising income during 1978.] ¶Action: REPORT FILED

● RESOLUTION 37—COMMITTEE ON NOMINATIONS. This resolution would prohibit a member serving on the Committee on Nominations from being nominated as a constitutional officer of the Society or as a delegate or alternate to the AMA by the Committee on Nominations. This Society's Bylaws (Chapter X) provide that its deliberations be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure, except as may be provided otherwise in the Constitution and Bylaws. We quote as follows from Sturgis:

> "Members who are likely to become candidates should not serve on a nominating committee. But members of the committee can become candidates. If they were barred from becoming candidates, supporters of one candidate might maneuver to place his prospective opponents on the nominating committee in order to disqualify them from candidacy. A member of a nominating committee who becomes a candidate should resign from the committee immediately."

Your committee therefore recommends that Resolution 37 not be adopted. ¶Action: RESOLUTION REJECTED

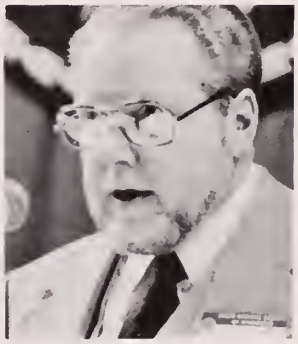
Chairman Frank
Reference Committee
on Finances

Doctor Faerster
for Chairman Watson
Reference Committee
Reports of Officers

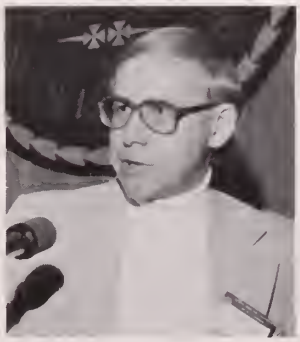
Chairman Asplund
Reference Committee
Resolutions-Amendments

Chairman Stannard
Reference Committee
Standing Committees

Chairman Haskins
Council



Speaker Matzel
House of Delegates



President-elect Treffert

President Levin

● RESOLUTION 38—Sponsors of Resolutions. This provides that resolutions which are properly submitted in other respects be given full consideration even in the absence of a sponsor from the county society sponsoring the resolutions. The committee discussed this resolution in conjunction with the 1974 House of Delegates action adopting a recommendation that for each resolution and report submitted, *a* sponsor be in attendance at reference committee hearings to provide any additional background which may be needed. This does not require that a sponsor from the county of origin be present and your reference committee therefore recommends the resolution not be adopted. ¶Action: RESOLUTION REJECTED

● RESOLUTION 39—*Implementation of House Actions.* This resolution requests that effective with the 1979 annual meeting, the delegates' materials include a synopsis of the previous year's House actions with a status report from the Council. Your committee was informed that such a report on 1977 actions was prepared for the Council's April 12 meeting with the thought that it would be reviewed and forwarded to the House of Delegates. However, the Council did not reach that item on the agenda before time ran out. Nevertheless, the status report on 1977 actions is [being distributed with] this report for the information of the House and the members it represents. Your committee recommends adoption of Resolution 39.
¶Action: ADOPTED

● COUNCIL REPORT T, PART 1—*Goals and Objectives.* Your committee recommends that this portion of Report T and the statement of goals, objectives and projects to be used by the Council as a continuing working document be filed. ¶Action: FILED

● COUNCIL REPORT T, PART 3—*State of the Society.* Your committee recommends that this portion of Report T be filed [reporting progress during the past year in several top priority areas as elaborated in other reports to the House.] ¶Action: FILED

● RESOLUTION 26—*Peer Review: Private vs Federal.* ¶Action: A reference committee substitute resolution 26, which resolved that the State Medical Society organize and support a statewide medical foundation responsible for coordinating and accomplishing all medical review activities, other than those that have been governmentally mandated (PSROs), was tabled at the second session until a report could be obtained from the Council Ad Hoc Committee on Peer Review which held several lengthy sessions during the annual meeting.

At the third session on April 15, Doctor LaBissoniere presented a report from the ad hoc committee which had been accepted by the Council at a 7 am session. A motion was made from the floor that the report of the *Ad Hoc Committee on Peer Review be accepted and substituted for Resolution 26;* seconded and carried. That report is quoted in full as follows:

By authority of the Council, the Ad Hoc Committee to review and make recommendations regarding implementation of peer review was formed and convened on April 13 and 14, 1978.

The committee perceived four basic goals considered essential in solution of the problem:

(1) Establish a mechanism to assess the quality and cost of medical care for all patients.

(2) Establish a mechanism to provide assurance to the profession and the public that quality and cost awareness exist.

(3) The responsibility for making decisions regarding the entire review process as well as the performance of the review itself should be that of the practicing physicians.

(4) The development of complete linkage between this mechanism with organized medicine to facilitate effective educational, disciplinary, legislative and related efforts.

The committee perceived five basic problems:

(1) The present existence of functioning PSROs.

(2) The historical existing problems between geographic areas.

(3) The anticipated sensitivity, individual or group, of physicians currently active in the PSRO process.

(4) The future of WHCRI.

(5) The urgent need for solution.

PROPOSAL AND SOLUTION:

In the light of the above considerations, the committee unanimously agrees that the ideal organization would be a single nonmembership foundation to provide peer review throughout the state, both private and federally mandated.

The Policy making board of such foundation could be provided in various ways at the discretion of the House and/or the Council and details could be elaborated following conference with these bodies and appropriate legal or other consultation.

Said Foundation through its membership, officers and staff to be closely receptive to appropriate leadership in state organized medicine.

After WisPRO, as presently designed, is reorganized similar to the UPRO (Utah) organization with direct linkage with the State Medical Society, the medical review function of WHCRI will no longer be necessary.

In the interests of cohesiveness and effectiveness of the medical profession of the State of Wisconsin and in consideration of the needs of the patient public, the Foundation would be statewide with the hopeful anticipation of the future association of the Foundation for Medical Care Evaluation and therefore ultimately the inclusion of all peer review in the State of Wisconsin.

Within the time allowed for committee study, action and conclusion, fiscal estimations are not feasible at this time. However, the committee is informed that at the time of a recent meeting of representatives of insurance, industry, labor, and the State Society, these agency participants had agreed to share financial responsibility. Accordingly, the financial impact on the State Medical Society is considered to be minimal but needs to be evaluated.

The alternatives to a proposal such as described in the foregoing expose organized medicine in the State of Wisconsin as well as health care review to needless and undesirable division, escalation of administrative and other costs, ultimately a poorly organized and inadequately functioning review process, and the very real specter of the intrusion of extra-medical controls.

In order to implement the concepts as presented, the ad hoc committee recognizes the need for an interim organization to function as a steering committee consisting of representatives of the Council,

FMCE, WisPRO, and others, medical and non-medical as indicated, to be named by the Council.

Paul G LaBissoniere, MD, Chairman
Antoine Barrette, MD
Irwin J Bruhn, MD
Timothy Flaherty, MD (absent)
Russell Lewis, MD
William Nielsen, MD
Blake Waterhouse, MD

● COUNCIL REPORT T, PART 2, AND SUPPLEMENTARY REPORT OF COUNCIL, ITEM 5, also relate to peer review. The committee recommends these be filed. ¶Action: FILED

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● REPORT B—COMMISSION ON PUBLIC INFORMATION—outlines the activities of the commission in detail and notes plans for the coming year. The reference committee commends the commission in its successful endeavors especially in the areas of membership recruitment and retention and in production of educational brochures for the public, and recommends adoption of this report.

¶Action: ADOPTED

● REPORT C—COMMISSION ON CONTINUING MEDICAL EDUCATION. The committee is impressed with the substantial accreditation program of the commission and is cognizant of the continuing efforts to develop successful continuing medical education programs. The reference committee commends the commission for efforts to provide educational opportunities in Wisconsin and recommends adoption of this report. ¶Action: ADOPTED

● REPORT D—COMMISSION ON HEALTH FACILITIES AND SERVICES. The committee noted the several activities of the commission during the past year, including involvement with regional health planning, dual surveys of hospitals, review of the state health plan and certificate of need standards, and educational programming. The committee commends the commission for its valuable efforts and recommends adoption of this report.

¶Action: ADOPTED

[Note: At a meeting following adjournment of the House, the Council changed the name of this commission to Health Planning.]

● REPORT E—COMMISSION ON MEDIATION AND PROFESSIONAL ETHICS. The committee notes the efforts of the commission related to the impaired physician and encourages its continued efforts in this regard, including consideration of means for further identifying the commission's role regarding the impaired physician. The reference committee congratulates the commission for its sensitive handling of the matters coming under its responsibility, and recommends adoption of this report. ¶Action: ADOPTED

● REPORT F—COMMISSION ON GOVERNMENTAL AFFAIRS, and its supplementary report, *Capitol Week*, provide a comprehensive and detailed description of the many crucial activities of this commission. The committee is impressed with the range of interests of the commission in dealing with legislative matters. The committee also recognizes the timeliness of the commission's creation of the subcommittee to become concerned with environmental health issues. The reference committee urges that all dele-

HOUGHTON MEDICAL STUDENT AWARD

Margaret Chen of Delavan, and Richard E Immler of Minocqua were announced as the 1978 recipients of the State Medical Society Houghton Award at the April Annual Meeting in Milwaukee. The Houghton Award is given yearly to two senior medical students from Wisconsin's two medical schools for "scholastic excellence, extracurricular achievement and interest in medical organization, who show a high promise of becoming a complete physician." Each recipient is given a $100 cash award and a plaque. The Houghton Award was established in 1968 by the late John H Houghton, MD, a Wisconsin Dells general practitioner who wanted to emphasize for future doctors the ideals used by the practicing physician. Later, John's brother, William J Houghton, MD, a Milwaukee surgeon, added to the fund.

Margaret Chen and Dr Robert M Senty

Margaret Chen attended Delavan-Darien High School and received a Bachelor of Science degree from the UW-Madison in 1973. She is a member of Alpha Omega Alpha, the National Medical Honor Society. Ms Chen has served on the Medical College of Wisconsin's Student Affairs Committee from 1974 to 1978, and has represented the school for the past three years in the Organization of Student Representatives of the Association of American Medical Colleges.

Richard Immler was unable to attend the award presentation on April 14, since he was out of the state serving a preceptorship. Mr Immler was born in Tomahawk, Wisconsin and graduated from Lakeland Union High School in Minocqua. He received his undergraduate degree in Mathematics, summa cum laude, from Marquette University and entered the University of Wisconsin Medical School in 1974. Immler has been involved in a variety of extracurricular activities. As an undergraduate he participated in the campus ministry, as a nursing home visitor, and was a member of a student government committee on review of student organizations. In medical school he helped to organize student/faculty course evaluation meetings of his class during his second year, assisted in informing students of the Family Practice Residency Program at Waukesha, and participated in the orientation of incoming students.

gates read the supplementary report, *Capitol Week*, as a portion of the work of the commission, and recommends adoption of Report F. ¶Action: ADOPTED

● REPORT J—COMMITTEE ON CANCER. Your reference committee notes the efforts of the committee to maintain liaison with other cancer control organizations and to monitor legislation regarding Laetrile, and recommends adoption of this report. ¶Action: ADOPTED

● REPORT K—COMMITTEE ON MATERNAL AND CHILD HEALTH. In addition to continued support of the committee's policy position in opposition to home delivery, the reference committee encourages the committee to continue discussion with state agencies concerning the arbitrary numerical standards for continued approval of hospital obstetrical programs, and recommends adoption of this report. ¶Action: ADOPTED

● REPORT L—JOINT PRACTICE COMMITTEE. This report explains the efforts of the State Medical Society with the Wisconsin Nurses Association in development of guidelines for implementation of joint practice of physicians and nurses. The reference committee commends the Joint Practice Committee for its fruitful efforts leading to the development and approval of these guidelines by the Council, and recommends acceptance of these guidelines by the House. ¶Action: ACCEPTED

● REPORT M—COMMITTEE ON MENTAL HEALTH. The report delineates the committee's concerns with administrative, legislative, and therapeutic aspects of mental health. The reference committee notes that the committee offered assistance to other commissions (Governmental Affairs and Mediation and Professional Ethics) in addition to the review of proposed administrative rules for funding psychotherapy services under Title 19 and proposed Mental Health Act legislation. The committee is to be commended for its activities, and we recommend adoption of this report. ¶Action: ADOPTED

● REPORT N—COMMITTEE ON OCCUPATIONAL HEALTH, outlines completion of the revision of the "Occupational Health Guide for Medical and Nursing Personnel" and its renewed efforts in its relationship with the Department of Industry, Labor and Human Relations, particularly the Worker's Compensation Division. The reference committee commends the committee and recommends adoption of its report. ¶Action: ADOPTED

● REPORT O—JAIL HEALTH CARE COMMITTEE. It is noted that a number of Wisconsin county jails have been accredited as having met minimum standards devised for the elevation of quality of health services and medical services in county jails. The reference committee lauds the Jail Health Care Committee for its work in achieving the committee goals, encourages it to pursue the plans for the current year, and recommends adoption of this report. ¶Action: ADOPTED

● REPORT R—COMMITTEE ON MEDICINE AND RELIGION. The reference committee is convinced that the efforts of this committee have contributed to the strength of the membership through its programs. The committee is commended and encouraged to pursue its goals, and your reference committee recommends adoption of this report. ¶Action: ADOPTED

● REPORT S—COMMITTEE ON SCHOOL HEALTH. The report outlines activities undertaken during the past year, especially with respect to the exceptional educational needs from age three. In addition to commending the Committee on School Health for its accomplishments during this past year, the reference committee urges that it pursue its evaluation of school health activities, and especially recommends that all school coaches and physical education teachers become trained in basic first aid and in cardiopulmonary resuscitation. ¶Action: REPORT ADOPTED

● RESOLUTION 23—*Mental Illness Coverage under National Health Insurance.* The resolution recommends that the State Medical Society petition the AMA to delete any differentiation between mental illnesses and other forms of illnesses, particularly with regard to eligibility for coverage when sponsoring a national health insurance program. Your committee recommends adoption of this resolution. ¶Action: ADOPTED

● RESOLUTION 27—*Commendation of Acting Governor Schreiber.* The resolution recommends that Acting Governor Schreiber be commended for his veto of chiropractic bill SB 108 as well as those senators who sustained this veto [in the interest of the public's health]. The reference committee recommends adoption. ¶Action: ADOPTED

● RESOLUTION 28—*Financial Support for Local Health Departments.* The resolution recommends that the State Medical Society request the legislature to increase financial support for local health departments. Increased funding of health departments is needed to support preventive medicine and public health education efforts. The reference committee opposes adoption of this resolution as presented, unless greatly improved physician supervision or involvement is established with local health departments. The committee recognizes the value of increased financial need for the public health program; however, it reiterates the necessity that local public health nurses must work more cooperatively with the physicians and that improved avenues of communication be encouraged.

¶Action: AN AMENDMENT PROPOSED BY DOCTOR BIEK AND RESOLUTION 28 REJECTED.

● RESOLUTION 29—*Deposition vs Court Appearance in Civil Procedures.* Your reference committee recommends adoption of this resolution recommending that the State Medical Society introduce legislation to amend the rules for civil procedure in order that a physician who has demonstrated reasonable availability for deposition may avoid service of a subpoena to appear in court. ¶Action: ADOPTED

● RESOLUTION 30—*Paramedical Organizations.* This resolution recommends that the State Medical Society support legislation to place examining boards of all paramedical organizations under the authority of the Wisconsin Medical Examining Board. Although the committee does not anticipate realization of the objective of this resolution, it supports the resolution and recommends its adoption. ¶Action: ADOPTED

● RESOLUTION 31—*Defined Hospital Privileges for Paraprofessionals.* The resolution recommends that the State Medical Society, in cooperation with the Wisconsin Hospital Association, develop guidelines to assist hospitals in amending their bylaws in order that paraprofessional personnel may apply for "affiliate" or other appropriate hospital staff membership categories. Because of the fact that hospitals already have guidelines, and because of the difficulty in interpreting the scope of the concept of paraprofessionals, the committee recommends that this report be filed and that hospitals continue to work within the frame-

work of the Joint Commission on Accreditation of Hospitals. ¶Action: ACCEPTED

● RESOLUTION 36—*Health Screening, Treatment, and Education Programs.* The resolution points out an increasing proliferation of private and public programs which conduct diagnostic screening, treatment and health education, many of which operate independently and without appropriate physician attendance or supervision, leading to fragmentation of patient care, duplication of existing resources, and possible delay in timely diagnosis and treatment. The reference committee supports the resolution and recommends that it be referred to the Council for appropriate committee assignment. ¶Action: REFERRED TO COUNCIL

REFERENCE COMMITTEE ON FINANCES

● RESOLUTION 6—*Dues Structure for Young Physicians.* The committee heard considerable testimony and discussed this resolution in detail while in closed session. While we agree with the intent of the resolution which is to provide some dues relief for the new physician, we recommend the following substitute resolve: That physicians elected to membership within six months of completion of residency, fellowship or fulfillment of government obligation such as the Berry Plan, who have been members of their state medical society for at least twelve full calendar months preceding such election, shall pay only 50% of regular member dues for the first year of membership, 75% for the second year, and full dues thereafter.
¶Action: SUBSTITUTE ADOPTED

● RESOLUTION 7—*Dues Structure for Young Physicians.* On the basis that the intent of the first resolve which speaks to reducing State Society dues for new physicians has been enacted by our recommendation on Resolution 6, your committee recommends this first resolve be rejected. ¶Action: RECOMMENDATION APPROVED

The second and third resolves for encouraging county medical societies and the AMA to make similar adjustments in their dues structures are recommended for adoption.
¶Action: ADOPTED

● RESOLUTION 8—*Creation of Senior Membership.* Introduction of this resolution yesterday in effect called for an addition to the Bylaws creating a senior membership category. In testimony and substantial discussion which covered the State Society's current policy, we concluded this should be added to the Bylaws and offer the following as an addition to Chapter I creating a new section to read as follows:

> SEC. 15. *Senior Membership.* Any member who has reached age 65 and practices 1,000 hours or less during a calendar year, but does not qualify for associate membership, may upon application, recommendation by the county medical society, and approval by the State Medical Society, be granted senior membership upon payment of 50% of regular member dues. Such change shall be effective January 1 following receipt of such request.

As nearly as we can determine here, there will be no change in the fiscal note [estimated annual reduction of dues of $10,000 and a one-time administrative cost of $1,000]. ¶Action: BYLAW AMENDMENT ADOPTED

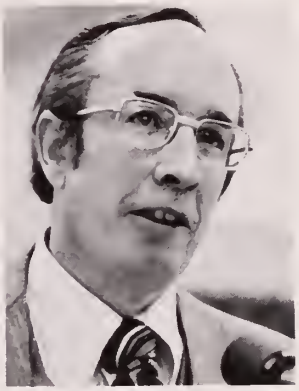
● RESOLUTION 9—*Alternative Methods of Dues Collections.* We heard testimony as to the reason for submission of this resolution as well as an explanation of the current dues installment payment plan available to members of the State Medical Society. We recommend rejection of this resolution because the present installment payment plan, in our opinion, is sufficient to accomplish the intent of this resolution. ¶Action: RESOLUTION REJECTED

● RESOLUTION 10—*World Medical and Health Affairs.* There was some testimony on this resolution; however, questions by the committee regarding the two organizations referred to were not completely answered. Your committee recommends rejection of the resolution because we feel it inappropriate for the State Medical Society to request the AMA to rejoin the World Medical Association and support the World Medical Organization. Furthermore, the second resolve would constitute an en-

Secretary Thayer

Vice-speaker Taebel
House of Delegates

Robert Durkin
Administrator, State
Division of Health



Donald Percy
Secretary, State Dept
Health, Social Services

President and Mrs Jules Levin

dorsement by the State Society and until more information is known about the World Medical Association, such endorsement should not be made.

¶Action: RESOLUTION REJECTED

● RESOLUTION 11—*Duplication by State Medical Society and Wisconsin Physicians Alliance.* After testimony and discussion in closed session, your committee recommends rejection of this resolution on the basis that the Physicians Alliance, which is a division of the State Medical Society and not a separate entity, has been successful in performing the tasks assigned to it on a cost-effective basis and that no change should be made at this time.

¶Action: RESOLUTION REJECTED

● RESOLUTIONS 12-18—WISCONSIN PHYSICIANS SERVICE—AND COUNCIL REPORT T, PART 4. There was considerable testimony and closed session discussion on these, which were covered under one subject. We recognize the past favorable relations that have existed between the State Medical Society and WPS. Furthermore, we recognize whatever action the House of Delegates takes on this matter today will only be advisory to the Council acting as the WPSIC membership which is the body that must take the final action. We recommend acceptance of the principles stated in resolutions 12 through 18 and in Part 4 of Council Report T, Option C, but in lieu of their adoption, your committee recommends adoption of the following substitute for all of the above:

Resolved, That the House of Delegates recommend that the Council as the corporate membership of WPSIC take steps to completely separate the State Medical Society from Wisconsin Physicians Service Insurance Corporation.

We make note of the second resolve in resolution 16 which speaks to the logo and the name WPS. It is our belief that the logo matter has already been resolved by action of the WPSIC membership in a meeting held in December of 1977, at which time the Bylaws were changed so as to protect current interests of SMS.

¶Action: SUBSTITUTE ADOPTED

● COUNCIL REPORT T, PART 5, AND ANALYSIS OF SUMMARY REPORT OF THE NATIONAL COMMISSION ON THE COST OF MEDICAL CARE. Your committee recommends this report and all sections of part 5 of the Council report, including analysis by the SMS committee, be adopted.

¶Action: ADOPTED

● 1978 BUDGET AND COUNCIL REPORT T, PART 6. We heard testimony and had considerable discussion on this subject. We recognize that anticipated expenses in 1978 will exceed income with resulting reduction of reserves. While that situation is something that cannot continue indefinitely, the reserves are there for a reason, that being to be used when needed, not necessarily preserved forever, and we feel 1978 is a time when some of those reserves are needed. If an increased level of activity, or even the same level, is to be maintained, this budget must be approved as presented so as to allow the Society to remain an effective organization. The committee recommends adoption of the 1978 budget as presented.

¶Action: ADOPTED

● 1979 DUES—COUNCIL REPORT T, PART 7. Considerable testimony was given on this matter and there was even more discussion in closed session. You have seen the inflationary effect on the Society's 1978 proposed budget, just as we have all seen it in our own practices. We concur with the Council report which recommends: "That the House of Delegates, beginning in 1979, implement the 1975 House action that dues be adjusted annually to recognize the effects of inflation on the Society's budget, so that annual dues be structured to reflect, but not to exceed, the annual CPI rate." The Consumer Price Index increase from 1976-77 was 6.5%. Using that as a base, your committee recommends regular member dues for 1979 be increased by $20, which is 6.7%, to an annual rate of $320, and that in establishing future years' dues the Consumer Price Index be used as part of the basis for determining those amounts so that there will continue to be an adequate amount of reserves for use when needed.

¶Action: APPROVED

● TREASURER'S REPORT AND AUDIT REPORTS. The report of the Society's Treasurer, Eugene J. Nordby, MD, was discussed. We acknowledge the continued improvement of the Society's financial position through December 31, 1977, but also recognize that the reason for some of that improvement is not one that can be counted upon in the future. We further recognize that 1978 will probably result in a short term reversal of that trend. We acknowledge Doctor Nordby's diligence in performing his Treasurer's function and thank him for the informative report. We recommend that the Treasurer's Report for 1977 and the audit reports be received. ¶Action: RECEIVED (See financial statements elsewhere in this issue.)

● SUPPLEMENTARY COUNCIL REPORT, ITEM 2, *Chapter 180 For Profit Corporation.* As a final item, your committee heard testimony and discussed this subject. We feel the concept of the Society entering into this area requires more background than was available, therefore we recommend this matter be referred back to the Council for reconsideration and if, in its best judgment, it continues to feel this should be undertaken, authority be given to do so. ¶Action: RECOMMENDATION APPROVED ■

THANK YOU!

The committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done."

Reference Committee on Reports of Officers: MDs Raymond R Watson, Milwaukee, chairman; Harry R Foerster, Jr, Milwaukee; J D Kabler, Madison; Bahri O Gungor, Neillsville; and Clarence M Scott, Jr, Superior.

Reference Committee on Reports of Standing Committees: MDs Gilbert H Stannard, Jr, Manitowoc, chairman; Richard H Ulmer, Marshfield; Timothy A Correll, Dodgeville; G Daniel Miller, Oconomowoc; and George V Murphy, Milwaukee.

Reference Committee on Resolutions and Amendments to the Constitution and Bylaws: MDs Merne W Asplund, Bloomer, chairman; Robert F Madden, Milwaukee; Milfred A Cunningham, Madison; James T Murphy, La Crosse; and Charles S Geiger, Jr, West Bend.

Reference Committee on Finances: MDs Jordon Frank, Beloit, chairman; Charles E Koepp, Marinette; Kenneth A Stormo, Fond du Lac; William E Martens, Wauwatosa; and Vernon M Griffin, Mauston.

Committee on Credentials: MDs George W Arndt, Neenah, chairman; George F Flynn, Milwaukee; and Carl B Weston, Madison.

ALBERT J MOTZEL, JR, MD
Speaker

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E. Gill & Company, certified public accountants, and reflect the general financial condition of the Society at December 31, 1977. ■ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: State Medical Society of Wisconsin (General Fund), Wisconsin Medical Journal, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., and Revised Employees' Pension Plan and Trust Agreement. ■ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1977

		State Medical Society	Wisconsin Medical Journal
INCOME			
Members 1977 Dues		$1,147,323.00	$ 19,560.00
Members Dues—Partial Year		5,659.50	
Income From Funds Invested		30,462.69	
Annual Meeting Income		27,961.50	
AMA Grant for Study of Health Care in Correctional Institutions		28,283.00	
Administrative Cost Recovery From Wisconsin Physicians Service Insurance Corporation		38,000.00	
Miscellaneous Income		33.77	
Loss on Sale of Fixed Assets		(276.02)	
Advertising Income			65,205.19
Subscription and Supplemental Income			1,946.12
Reprint Income			2,619.06
AMA Collection Fees		6,870.43	
TOTAL INCOME		$1,284,317.87	$ 89,330.37
EXPENSES			
Payroll		$ 504,310.51	$ 30,716.70
Payroll Related Costs		121,911.82	11,046.52
President and President Elect Travel		3,868.22	
AMA Annual Clinic and Special Meetings		11,400.00	
Association Dues		2,835.95	
Conference Expense		40,324.30	421.00
Travel Expenses		95,819.88	935.04
Telephone Expense	$77,539.39		
Less Telephone Costs Recovered	44,750.43	32,788.96	1,904.55
Printing and Forms		51,291.86	1,071.11
Postage		39,270.94	3,619.96
Promotion		79.72	
Insurance—General		14,178.83	573.87
Grants and Appropriations		8,030.00	
Cafeteria Expense	$19,332.67		
Less Cafeteria Costs Recovered	16.650.76	2,681.91	228.47
Speakers Expense		6,785.97	
Office Services		53,723.35	2,297.56
Outside Services		37,384.11	4.12
Miscellaneous Expense		8,113.94	1,820.74
Accounting Service		5,793.72	902.67
Legal Counsel		62,318.04	636.00
Depreciation		3,850.62	350.72
Office Rent		62,411.43	3,892.89
Resource Material		3,660.76	168.55
Journal Printing—Net of Reimbursed Costs			37,847.58
Other Publication Expenses			2,144.85
Advertising Expense			13,834.18
Uncollectible Items			321.70
Total		$1,172,834.84	$114,738.78
Less Portion of Above Expenses Recovered by Services Furnished to Others		33,765.97	
NET EXPENSES		$1,139,068.87	$114,738.78
Excess Income Over Expense Before SMS Realty Corporation		$ 145,249.00	($25,408.41)
SMS Realty Corporation Distribution of 1976 Income	$15,269.14		
Less State Medical Society Donation to Capital of SMS Realty Corporation	6.888.13	8,381.01	
Net Income Over Expense		$ 153,630.01	($25,408.41)
General Fund Excess Income Over Expenses		$128.221.60	

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin
BALANCE SHEET
December 31, 1977

ASSETS		
Current Assets		
Cash		$ 230,694.99
Employee Travel Advance		3,667.45
Accounts Receivable-General		82,174.09
Due From Wisconsin Physicians Service Insurance Corporation		88,797.93
Due From Employees Pension Plan		536.17
Due From Charitable, Educational and Scientific Foundation, Incorporated		3,683.72
Due From Wisconsin Medical Journal Advertisers		9,429.72
Due From Other Organizations for Accrued Payroll and Vacation Pay		48,776.96
Certificates of Deposit		650,000.00
Commercial Paper		442,888.12
Common Stock at Cost (Market Value $10,854.75)		8,361.52
Accrued Investment Income Receivable		3,470.81
Prepaid Expenses		27,422.29
Printing and Forms Inventory		13,438.90
Total Current Assets		$1,613,342.67
Fixed Assets		
Furniture and Equipment	$ 111,075.53	
Less: Accumulated Depreciation	71,102.66	
Total Fixed Assets		39,972.87
TOTAL ASSETS		$1,653,315.54
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable		$ 43,973.03
Due SMS Realty Corporation		37,746.54
Dues Held for Milwaukee Auxiliary		5,947.00
Dues Held for Section on Ophthalmology		15,097.88
Accrued Payroll Taxes and Other Payroll Deductions		5,204.15
Unapplied Membership Dues		2,855.75
Accrued Property Taxes		1,827.35
Accrued Payroll and Vacation Pay		121,868.22
Retirement Plan Contribution Payable		11,559.05
Advertising Commissions Payable		2,682.41
Other Liabilities		255.33
Total Current Liabilities		$ 249,016.71
Deferred Income		
Prepaid Membership Dues	$1,124,933.00	
Other Prepaid Income	7,809.10	
Total Deferred Income		$1,132,742.10
Total Liabilities		$1,381,758.81
NET WORTH		
Capital of General Fund, January 1, 1977	$ 143,335.13	
Income Over Expense—1977 Operations	128,221.60	
Total Capital, December 31, 1977		271.556.73
TOTAL LIABILITIES AND GENERAL		$1.653.315.54

EDITOR'S NOTE: Notes accompanying the foregoing statements in the original Certified Audit are not included here because of space limitations. ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

Madison, February 4, 1978

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 11:10 am on Saturday, February 4, 1978, at the State Medical Society.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Doctors Schmidt, Foley, Nielsen, Bruhn, Steffen, LaBissoniere, Mullooly, Eisenberg, Crowley, Tuftee, Waterhouse, Natoli, Kief, Lewis, Peters, Flaherty, Smejkal, Barrette, Doyle, Picard, Larsen, Levin, Motzel, and Taebel.

Others present (part or entire): Doctors Nordby, Derus, Twelmeyer, Collentine, Williams, Scott, HJKief, Stuff, Grover, Lubitz, Viste, Kriss, Kempthorne, Wear; Dr and Mrs Lyons; Messrs Thayer, Maroney, Johnson, Wendle, LaBissoniere, Brower, Jensen, Nelson, Opin, Mendelson, Stromer; Mmes Bartel, Price-Marcus, Upton; Miss Pyre; Dr Gertler and Cameron Brown, WHCRI; Donald McIntyre and Atty Grams, WisPRO.

2. Approval of Minutes

There being no additions or corrections the minutes of the December 10, 1977, meeting were declared approved as distributed.

There was a request for an update at the next meeting on development of a position paper on nurse practitioners.

3. State Health Plan

Mr Thayer reported his request that the chairman of the Health Policy Council Plan Development Committee seek to have each section of the draft State Health Plan rewritten by a small task force having representation from the medical specialty concerned, and to postpone final action by the HPC. He also informed the Council that the Commission on Health Facilities and Services was to meet on February 16 and develop a position paper which can be sent to county and specialty societies for use at public hearings.

On motion of Doctors Larsen-Edwards, carried, the Council approved the recommendation of the Executive Committee that the Commission on Health Facilities and Services and staff be charged with the responsibility of developing a general response to the Wisconsin State Health Plan, without reference to specific items in minute detail, based on comments received from representatives of specialty societies and others to whom the plan has been sent for review.

4. Report of Executive Committee

A. WPSIC

The committee reported its belief that inasmuch as resolutions have been received for introduction to the House of Delegates calling for total separation of SMS from WPSIC, the Council should express an opinion on the matter in its report to the House, even though such an action would ultimately have to be taken by the Council meeting as the corporate members of WPSIC.

On motion of Doctors Larsen-Lewis, carried, the motion of Doctors Larsen-Picard at the October 15, 1977, Council meeting, that the Society complete the separation from WPSIC as expeditiously as possible, was removed from the table.

Doctors LaBissoniere-Mullooly moved adoption of Option C (one of four options presented at the October meeting) to "complete the separation of WPSIC from the State Medical Society." The motion carried by a roll call vote of 21-5.

The secretary inquired whether it was intended that the page of information relating to Option C, including some of the advantages and disadvantages, was to be reported to the House of Delegates. The chairman responded that the House should be given the information on all of the options as reported to the Council in October.

Prior to the vote, Doctor Motzel inquired as to the possibility of the joint meeting with the WPSIC Board of Directors, including the new members, which he had proposed in October, again suggesting it be held before taking the above action. Doctor Haskins advised that Doctor Goldstein, secretary of WPSIC, had requested postponement of a joint meeting until July; that such a meeting could still be held after the House acts since this would be advisory to the Council as the corporate membership.

B. Proposed Amendment of Rule on "Roving" by Alternate Delegates

On motion of Doctors Larsen-Picard, carried, the Council approved the following wording for recommendation to the House.

"An alternate delegate representing a county medical society may serve as alternate for any duly elected delegate from that county society only, and may not serve as alternate for a delegate from another county medical society. Delegates and alternates elected to represent specialty sections may not substitute as county medical society delegates or alternates, but may serve as specially appointed delegates for their county medical societies."

C. Update of Constitution and Bylaws

The Council was informed that the committee has requested staff to develop proposed revisions with special attention to due process provisions in reference to disciplinary procedures.

D. Title 19 Informational Report

Council members received a copy of the latest draft of "Super Rule" (to which an addendum has subsequently been made by DHSS) together with comments by staff and legal counsel on provisions considered to be the most significant to the interests of physicians and Title 19 patients. Hearings on the rule are scheduled beginning February 13 through the 27th. The Physicians Alliance Commission and staff have been working with the Department on the rule for months and will continue to negotiate for an acceptable document.

The Medicaid contract is regarded as a separate issue and its terms have been negotiated as well. All physicians will receive a contract probably in April or May for execution by July 1 in order to be reimbursed for services to Title 19 patients. Presumably the contract will have attached "terms of reimbursement" providing for payment for the one year term of the contract at the rate of reimbursement under Medicare. However, the Department has asked whether the Society wishes to reopen for negotiation the subject of reimbursement. The Physicians Alliance Commission and the Council's Cost Evaluation Committee plan a fact gathering February 17 meeting with the carriers on how Medicare profiles are developed, and then will consider the impacts of possible changes in determining reimbursement. It is intended that the Society communicate with all physicians in timely fashion to aid in their decision on signing the contract.

E. Awards

In executive session, the Council unanimously approved the nomination for the Council Award presented by the committee. It also delegated authority to the committee to consider and act on any subsequent nominations for the Presidential Citation or Civic Leadership Award in 1978.

F. AMA Regional Conferences

The AMA has announced a series of regional conferences designed to increase communication with members of the AMA House of Delegates and to discuss state implementation of AMA programs. On motion of Doctors Larsen-Picard, carried, the Council approved the recommendation that the Society reimburse expenses for those wishing to attend among the invitees to include members of the delegation and officers.

G. Council Positions on 1977 Assembly Bill 281

On motion of Doctors Mullooly-Levin, carried, the Council adopted a statement strongly opposing the enactment of this dangerous legislation which would allow optometrists to utilize "diagnostic" drugs in their practice, such position to be communicated to the legislature, news media, and SMS membership.

H. Vote of Thanks on Chiropractic Bill Veto

On motion of Doctors Larsen-Edwards, carried, the Council requested the secretary to express its thanks to the field consultants in particular for their efforts in connection with the Governor's veto of SB 108—mandatory chiropractic insurance.

5. Physicians Alliance Commission

Doctor Kriss reviewed the work of the ad hoc committee on professional liability created about three years ago with representation from the Council, the PAC, and certain other special interests. He reported the recommendation of the Commission that the original committee be dissolved and a permanent committee responsible to the PAC be appointed by it to monitor all aspects of the subject on a continuing basis.

On motion of Doctors LaBissoniere-Smejkal, carried, this recommendation was approved, and the Council commended Doctor Kriss and his committee for its past accomplishments.

Doctor Viste commented briefly on an activities report from the Commission which was distributed to the Council.

6. Executive Session

In executive session following luncheon recess, the Council adopted a protocol (copy attached to original minutes) for the conduct of an appeal from conclusions of the Commission on Mediation and Professional Ethics held later in the afternoon, also in executive session.

After hearing the appeal, a motion was adopted that in terms of the physician, the Council refer the matter to the Commission on Peer Review for further investigation of the pattern of care and defer action on the conclusions of the Commission on Mediation and Professonal Ethics until a report is received from the Commission on Peer Review; secondly, in terms of the county medical society. the Council recognize that they are taking steps to correct deficiencies that have been pointed out to them.

7. Governmental Affairs Commission

The Commission reported legislative activities of the current floor period, with specific reference to development of a statutory definition of death and occupational licensing proposals; also its concern with recent laboratory certification regulations.

Doctor Lubitz noted difficulties experienced by the Commission in securing advice on legislative proposals related to mental health through existing structures, and reported its recommendation that the SMS Committee on Mental Health be urged to provide the help needed or, as an alternative, that the Commission be authorized to appoint its own subcommittee.

Doctor Larsen informed the Council that the Nominating Committee, when it reports in April, would recommend some new membership for this committee which may have the desired effect of renewed activity on legislative and other matters related to mental health.

8. Private Patient Peer Review in Wisconsin

A "steering committee" representing the Council, WHCRI, WisPRO, and FMCE, appointed after the last Council meeting to discuss possibilities of a coordinated statewide private patient peer review program, held a second meeting on February 3. Doctor Larsen reported its unanimous recommendation to the Council and moved adoption as follows:

> That a 15 member special committee, composed of five physicians appointed by the Council, five by WisPRO, and five by FMCE, report back in 45 to 60 days their ability to agree on a policy plan for private review throughout the state including its relationship to continuing education, mediation and ethics; such group to be chaired and convened by Doctor Larsen until it finishes a recommendation to the Council.

This motion was seconded by Doctor Eisenberg and carried after lengthy discussion.

The intent of a second recommendation was reported to the Council by Doctor Waterhouse, who moved adoption as follows:

> That the SMS Council go on record as being strongly opposed to the separate incorporation of WisPRO until such time as the Council has received and acted upon the ad hoc committee's final report. Until the SMS Council has acted upon this report, any unilateral continuation of WisPRO efforts at separate incorporation will be viewed by this Council to be in direct conflict with what the Council believes to be the best long range interests of the SMS and of the profession.

This motion was seconded by Doctor Edwards and carried, Doctors Peters, Taebel and Kief voting in the negative.

9. Committee on Evaluation of Delivery and Cost of Medical Care

Doctor Waterhouse presented recommendations of the committee related to voluntary cost containment activities:

A. Report of National Commission on the Cost of Medical Care

On motion of Doctors Waterhouse-Tuftee, carried, the Council authorized the committee to proceed with distribution of its comments on recommendations in this report to the SMS House of Delegates with the understanding that the Council may propose revisions in the committee report at its April meeting.

B. SMS-WHA Media Program on Cost Containment

The Council received an outline of a proposed media program for public communication of voluntary cost containment activities by medicine and hospitals.

On motion of Doctors Waterhouse-Crowley, carried, the Council authorized the committee to oversee the expenditure of up to $3,000 for such a media program.

C. Cost Containment and the Physician

The Council approved preliminary plans for a program to be held the morning of April 13 in conjunction with the annual meeting.

10. Report of the Secretary

Mr Thayer reported that Mr Brower would be employed half time effective March 1 with reassignment of some of his responsibilities; that a new employee will undertake development of membership services and benefit programs; and that steps will be taken to assure staffing for health planning.

He asked that councilor district meetings be scheduled during March following distribution of the delegates handbooks.

11. Adjournment

The meeting adjourned at 6:20 pm.

EARL R THAYER
Secretary

Approved April 12, 1978
PAUL S HASKINS, MD
Chairman

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of April 4, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BARRON-WASHBURN-BURNETT

Burns, Charlotte A, 904 N Lake St, Rice Lake 54868 (1939, Regular, Ophthalmology, Certified)
Burns, James A, 904 N Lake St, Rice Lake 54868 (1939, Regular, General Surgery, Certified)

DANE

Kolar, Britton W, 777 S Mills St, Madison 53715 (1946, Resident, Family Physician)
Lempert, Kenneth D, 4833 Sheboygan Ave, #325, Madison 53705 (1947, Resident, Internal Medicine)
Perea, Alejandro A, 1300 University Ave, Madison 53706 (1945, Resident, Traumatic Surgery/General Surgery)
Schwettmann, Rick S, 1300 Universit Ave, Madison 53706 (1944, Regula Anesthesiology, Certified)
Warrick, James D, 777 S Mills St, Mad ison 53715 (1926, Regular, Famil Physician, Certified)

GREEN

Estes, Glen, 1515 10th St, Monroe 5356 (1946, Regular, Psychiatry)
Estes, Jeanne M, 1515 10th St, Monro 53566 (1946, Regular, Psychiatry)

MANITOWOC

Blank, Roy C, 601 Reed Ave, Mani towoc 54220 (1946, Regular, Interna Medicine, Certified)
Keller, Thomas A, 21st and Wester Ave, Manitowoc 54220 (1945, Regula Diagnostic Radiology/General Prac tice, Certified-R)

MILWAUKEE

Albers, James W, 8700 W Wisconsin Ave Milwaukee 53226 (1943, Regular, Neu rology)
Berland, Lincoln L, 5349 N Kent Ave Milwaukee 53217 (1949, Resident Radiology)
Glasspiegel, John S, 2400 W Lincoln Ave Milwaukee 53215 (1948, Regular, Pedi atrics)
Johnson, Martin G, 908 S Milwauke Ave, South Milwaukee 53172 (1947 Regular, Family Physician)
Wolkomir, Michael S, 5000 W Chambers Milwaukee 53210 (1947, Resident, Ob stetrics and Gynecology)

ONEIDA-VILAS

Kotila, Bruce A, 210 Elm Court, Rhinelander 54501 (1948, Regular, Interna Medicine, Certified)

OUTAGAMIE

Haight, Richard O, 1523 Madison St Appleton 54911 (1949, Regular, Family Physician)
Moore, Brian P, 1506 S Oneida St, Appleton 54911 (1941, Regular, Pathology, Certified)

PORTAGE

Casebolt, Donald E, 1800 Sherman Ave Stevens Point 54481 (1927, Regular General Practice)
McGinnis, Kathleen J, 950 Portage St Stevens Point 54481 (1951, Regular General Practice)

WASHINGTON

Hammer, Todd J, 1201 Oak St, West Bend 53095 (1947, Regular, Family Physician)
Heyl, Peter S, PO Box 397, Keshena 54135 (1949, Regular, Family Physician)

continued on page 53

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SMS ORGANIZATIONAL . . .

continued from page 48

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

DANE

Evans, Bruce W, Middleton, to 2323 N 7th, Grand Junction, CO 81501

EAU CLAIRE-DUNN-PEPIN

Cameron, William G, Eau Claire, to 250 Palmer Blvd, Six Lakes Ctry Clb Est, North Fort Myers, FL 33903

MANITOWOC

Thorpe, Robert F, Manitowoc, to Pediatric Clinic, McDonald Army Hospital, Fort Eustis, VA 23604

MILWAUKEE

Goldberg, Nat, Key Biscayne, FL, to 1610 N Prospect Ave, Milwaukee 53202

Kassowitz, Karl E, Milwaukee, to 1755 View Point Rd, Boulder, CO 80303

Wilkinson, Eward D, West Allis, to 13625 Underwood Parkway, Elm Grove 53122

ROCK

Farnsworth, R W, Pompano Beach, FL, to 1324 E Racine, Janesville 53545

DEATHS

DeWitt, Chester A, Kenosha County, Jan 26, 1978

Lauerman, Edward P, Racine County, Mar 10, 1978

Tasche, Leslie W, Sheboygan County, Mar 11, 1978 ■

OBITUARIES

◈County, State, AMA Members

◈ **David E Davidoff, MD,** 51, Milwaukee surgeon, died December 15, 1977 in Aruba, Dutch Antilles, while vacationing with his wife on the island. His untimely death shocked the Milwaukee community where he was considered a "gentle, soft spoken, distinguished scholar and magnificent surgeon . . . he set an example of tireless energy, a limitless devotion to his patients, and the highest ethical standard of medical care." He also was an avid scuba diver and an award winner in boating.

Born July 2, 1926 in Milwaukee, Doctor Davidoff graduated from the Washington School of Medicine in St Louis in 1952. He served his internship in the Beth Israel Hospital in Boston followed by a four-year surgical residency as a Harvard Research Fellow. He then opened his practice in Milwaukee and became a board certified surgeon.

He is survived by his widow, Evelyn, and four children: Donna, a senior in the Medical College of Wisconsin; Debbie, John, and Ronald, all in school. He also is survived by his father, Isadore Z Davidoff, MD of Shorewood.

◈ **Armand J Quick, MD,** 83, Milwaukee, a worldwide authority on bleeding diseases, and professor emeritus of Biochemistry at the Medical College of Wisconsin, died Jan 26, 1978 in Milwaukee. Born July 18, 1894 in Theresa, Doctor Quick received his medical degree from Cornell Medical College, New York, in 1928. He became associated with Marquette University School of Medicine in 1935 as professor and chairman of the biochemistry department and retired in 1964 only to continue as research professor of the college's hemostasis laboratory and then retired again in 1971. In 1932, he developed the Quick Test while in New York, and in 1947, he developed the prothrombin consumption time test, and in 1966 the aspirin tolerance test. In 1972 Doctor Quick's most recent achievement was the discovery of a new vitamin called vitamin Q.

Author of numerous articles and books, Doctor Quick received many honors throughout the nation and among them were: The Council Award from the State Medical Society of Wisconsin in 1950; the First Distinguished Service Award for Research in Medical Science, 1964, from the State Medical Society; and he also was elected in 1971 to the French National Academy of Medicine. *The Wisconsin Medical Journal* honored him with a "Festschrift" in 1967, for his many years of dedicated research and teaching.

Surviving are his widow, Margaret; and one daughter, Mrs Richard (Edith) Ebel of Blacksburg, Va.

◈ **Donald Elton Winnik, MD,** 60, Glendale, died Jan 26, 1978 in Milwaukee. Born June 13, 1917 in Milwaukee, Doctor Winnik graduated from Marquette University School of Medicine in 1943. He served in the United States Navy during World War II. He was on the medical staff of Mount Sinai Medical Center and Family Hospital and also was the medical director of Mount Carmel nursing home. Surviving are his widow, Sondra; two daughters, Judy Kieker, Minneapolis, Minn, and Marybeth Berkson, Glenview, Ill; and two sons, Joel of Washington, D C, and Dr Mitchell, Toronto, Canada.

◈ **Frederick Charles Heinan, MD,** 68, Tucson, Ariz, died Feb 6, 1978 in Tucson. Born Aug 21, 1909 in Milwaukee, Doctor Heinan graduated from Marquette University School of Medicine in 1934, and practiced in the Milwaukee area until he moved to Tucson in 1973. He served in the United States Navy from 1943 to 1946 during World War II. Surviving are his widow, Ebba; one son, James, Morgan Hill, Calif; and two daughters, Mrs Ruth Springob, Milwaukee and Mrs Carole Hanzel of New Berlin.

◈ **Gilbert Frederick Mueller, MD,** 83, Milwaukee, died Feb 18, 1978 in Milwaukee. Born Jan 26, 1895 in Milwaukee, Doctor Mueller graduated from Northwestern University Medical School in 1920. He served in the United States Army Medical Corps during World War I, and practiced medicine in the Milwaukee area for 50 years retiring in 1965. Surviving are his widow, Jeannette; one daughter, Barbara Boyd of Cambridge City, Ind; and two sons, Gilbert F, Jr, MD, Appleton and James A of Brussels, Belgium.

James Joseph Leahy, MD, 57, former Park Falls physician, died Feb 19, 1978 in Omaha, Neb. Doctor Leahy was born Feb 27, 1920 in Butternut, Wis, and graduated from Northwestern University Medical School in 1945. He practiced with his father, Justin D Leahy, MD, Park Falls, until 1959 when he moved to Nebraska. Surviving are his widow, Kay; three daughters, Joan, Janet, Marcia; and four sons, James, Keven, Robert and David, all of Omaha.

Orville E Damp, MD, 72, formerly of Birnamwood, died Mar 6, 1978 in Marshfield. Born Apr 29, 1905 in Milwaukee, Doctor Damp graduated from the Marquette University School of Medicine in 1930. He practiced medicine in Birnamwood until 1969 when he became a physician for the Grand Army Home at King, Wis. In 1975 he was a physician at the Veterans Hospital, Iron Mountain, Mich, until his retirement in 1977. Surviving are his widow, Donna; a son, Craig, Milwaukee; and three daughters, Mrs Earl (Patricia) Peterson, Eland; Mrs Bonnie Pomasl, Wauwatosa; and Mrs Roger (Susan) Knight of Wausau.

◈ **Edward P Lauerman, MD,** 54, Racine, died Mar 10, 1978 in Racine. Born Oct 3, 1923 in Chicago, Ill, Doctor Lauerman graduated from the University of Chicago Medical School in 1948. He served in the United States Army from 1943-1946 and the United States Air Force from 1951-1953. Doctor Lauerman had practiced in Racine since 1954. Surviving are his widow, Evelyn; and three sons, Timothy, Marc, and Tod all at home.

◈ **Leslie W Tasche, MD,** 79, prominent Sheboygan physician, died Mar 11, 1978 in Sheboygan. Born Dec 30, 1898 in Sheboygan, Doctor Tasche graduated from Columbia College of Physicians and Surgeons in 1924. He served as president of the medical staff of Sheboygan Memorial, St Nicholas, and Plymouth hospitals, and also as president of Sheboygan County Medical Society. Doctor Tasche performed the first operation at Memorial Hospital when it opened in 1933 and also in 1970, when the hospital remodeled its operating rooms. Doctor Tasche retired from practice in 1977. Surviving are his widow, Julie; one daughter, Mrs Helen DuBois North, Warren, Vt, and one son, Dr Conrad Tasche, chief of plastic surgery at Cook County General Hospital, Chicago. ■

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WPS

report

for Wisconsin Physicians

Volume VII, Number 3 May 1978

THE MEDICARE COMPANION

In May, 1959, seven years before the advent of Medicare, WPS offered a fee-for-service health policy called the Century Plan which provided surgical, medical, hospital and nursing home benefits for subscribers over 65. When Medicare was implemented in 1966, WPS developed the Medicare Plus contract to help pay health care expenses not completely covered by Medicare. Now, in 1978, WPS continues its tradition of providing good Medicare supplement coverage to the elderly through a new policy called the Medicare Companion.

The Medicare Companion will take the place of WPS' former Medicare supplement contract Medicare Plus and is designed to assist over-65 subscribers pay Medicare deductibles and co-insurance and extend exhausted Medicare benefits to the maximum limits of their WPS coverage.

The Medicare Companion provides a maximum benefit of up to $30,000 per benefit period. A "benefit period" refers to the period of time beginning with the effective date of the policy. A new benefit period begins with each readmission to the hospital after the subscriber has been out for at least sixty consecutive days.

The premium charged for the Companion policy is suited to most retirement incomes: $17.60 a month or $211.20 annually. This is the lowest premium for any supplemental policy yet approved by the Insurance Commissioner's office.

The Medicare Companion falls into Category 2, one of four categories of Medicare supplement policies established by the Commissioner of Insurance. As explained in the booklet *Health Advice for Senior Citizens,* "Medicare Supplement 2" policies supply major, broad-based protection against catastrophic and less serious illnesses.

Subscribers who presently enjoy coverage under Medicare Plus can continue to do so even though the new policy is available. With certain exceptions, however, the Medicare Companion will be the only Medicare supplement policy offered by WPS in the future. Medicare Plus subscribers who wish to convert to Medicare Companion will, of course, be able to do so.

If you are interested in learning more about any of the specific benefits of the Medicare Companion, or receiving a copy of the Outline of Coverage, please contact WPS Inquiry Services, 1717 W. Broadway, P.O. Box 8190, Madison, WI 53708, (608) 221-4711.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

***Report** is a service to the physicians of Wisconsin.*

11440-006-7804

EMERGENCY MEDICAL CARE

The WPS health insurance policy that many subscribers hold provides benefits for services rendered in either an outpatient department of a hospital or in the physician's office for emergency medical care. "Emergency medical care" means care rendered by a physician immediately after the onset of sudden, unexpected and severe symptoms.

The following list contains some examples of the type of diagnosis or conditions which WPS classifies under the benefit provision of "emergency."

- Acute allergic reactions
- Acute asthmatic attacks
- Convulsions
- Epileptic seizures
- Acute hemorrhage
- Acute appendicitis
- Acute or suspected poisoning
- Coma
- Heart attack
- Attempted suicide
- Suffocation
- Stroke
- Drug overdoses
- Loss of consciousness
- Any condition for which the patient is immediately admitted to a hospital as an inpatient

WPS receives claims for both hospital outpatient departments and physician locations that can be classified as "emergency medical care." If the diagnosis on the claim report form clearly conforms with WPS emergency benefit guidelines, payment is allowed without question. But if the information on the claim is not complete, or if the service was clearly not emergency treatment, the claim may be denied as not emergency medical care.

Let's take an example. It's three o'clock in the morning. A subscriber's child has a temperature of 104 degrees and is vomiting. The parents rush their child to the emergency room of the hospital for an examination. In their own minds, they wouldn't hesitate to classify this situation as an emergency. But when the claim form is received at the WPS office, the diagnosis may simply state "flu". The diagnosis is correct, but the hospital neglected to describe the severity of the illness. WPS cannot consider every claim indicating flu as an emergency.

In cases like these, the claim may be denied (reason 20 on the Explanation of Benefits). If the subscriber or physician sends us additional information, WPS staff would then review the claim for payment in light of the additional information.

The thing to remember is that **what actually happened** -- what the subscriber feels is truly an emergency case -- is not always fully reported on the claim form to WPS.

WPS believes that whenever possible, the subscriber should contact his or her family physician before seeking emergency medical care. WPS feels that the physician is in the best position to give the subscriber guidance as to how to proceed.

CONTINUING MEDICAL EDUCATION
MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 Wisconsin

May 26: University of Wisconsin Medical Alumni Day, Madison.

May 28: University of Wisconsin Commencement, Madison.

Jun 6: *The Coming of Age,* Seminars on Long-Term Care, Madison. Info: Contact WHCRI, 330 E Lakeside, Madison, Wis 53715. Tel: 608/257-6781.

Jun 7: *The Coming of Age,* Seminars on Long-Term Care, Eau Claire. Info: Contact WHCRI, 330 E Lakeside, Madison, Wis 53715. Tel: 608/257-6781.

Jun 8: *The Coming of Age,* Seminars on Long-Term Care, Green Bay. Info: Contact WHCRI, 330 E Lakeside, Madison, Wis 53715. Tel: 608/257-6781.

Jun 9: *The Coming of Age,* Seminars on Long-Term Care, Milwaukee. Info: Contact WHCRI, 330 E Lakeside, Madison, Wis 53715. Tel: 608/257-6781.

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

1978 NEIGHBORING

Sept 7-11: *Medical Knowledge Self-Assessment Program Course,* Towsley Center, Ann Arbor, Mich. Info: Registrar, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Sept 26-30: *Medical Knowledge Self-Assessment Program Course,* Mayo Civic Auditorium, Rochester, Minn. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

Oct 10-14: *Medical Knowledge Self-Assessment Program Course,* Ambassador West Hotel, Chicago, Ill. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

AMERICAN MEDICAL ASSOCIATION

127th Annual Convention

June 17-22, 1978—St Louis

I. Scientific Program—St Louis Gateway and Exhibition Center

—Scientific and industrial exhibits, Saturday thru Wednesday

—Postgraduate courses, Saturday thru Wednesday

—General scientific session, Saturday thru Wednesday. (The complete convention program is available in the April 17 issue of the *JAMA.*)

II. House of Delegates—Chase-Park Plaza Hotel

—The bi-annual session of the House of Delegates will commence Sunday, June 18. The House will continue to meet daily thru Thursday.

INFO CONTACT: AMA Housing Bureau, % St Louis Convention & Visitors Bureau of Greater St Louis, 500 North Broadway, St. Louis Mo 63102; or Ms Debbie Sweet, AMA Public Relations, 535 North Dearborn, Chicago, Ill 60610; or phone 312/751-6601.

1978 OTHERS

June 17-18: Fifth Annual UCLA Biofeedback Seminar: *Practical Applications of Biofeedback in the Health Sciences,* at Los Angeles Marriott Hotel, Los Angeles, Calif. Approved for 12½ hours of Category I credit toward CMA Certificate in CME and the AMA Physicians Recognition Award. Fee: $185. Info: Health Sciences, UCLA Extension, PO Box 24902, Los Angeles, CA 90024 or call 213/825-5840. g3-5/78

ASPEN MUSHROOM CONFERENCE

Identification of edible, poisonous, and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA category I. August 13-18, 1978. Wildwood Inn, Snowmass-at-Aspen, Colorado. Contact Beth Israel Hospital, 1601 Lowell Blvd, Denver, Colo 80204. Tel: 303/825-2190, ext 359. 5-6/78

THE COMING OF AGE
Seminars on Long-Term Care

Wisconsin Health Care Review, Inc (WHCRI) will present state-wide seminars on the administration and documentation of medications for long-term care residents and the intricacies of levels of care determinations:

- **Tuesday: June 6, Madison**
- **Wednesday: June 7, Eau Claire**
- **Thursday: June 8, Green Bay**
- **Friday: June 9, Milwaukee**

These one-day seminars will be of special interest to physicians involved in long-term care (medical directors, attending physicians), consultant pharmacists, nurses, nursing home administrators, social workers and any other health care professional in long-term care.

Topics include:

Drugs Affecting the Aged—Joseph M Tobin, MD

Documentation of Medications—Louis Hefle, RPh

Professional Judgment in Levels of Care Determination (Group Exercise)—Nurse Consultant Supervisors, Wisconsin Department of Health & Social Services

Registration materials and further information may be obtained by contacting: WHCRI, 330 East Lakeside St, Madison, Wis 53715. Tel: 608/257-6781.

Sep 11-13: American Cancer Society *National Conference on the Care of the Child with Cancer,* at The Sheraton-Boston Hotel, Boston, Mass. Attendance open to all members and students of the medical, nursing, and related health professions. Advance registration requested. No registration fee. Accredited for CME. Info: Sidney L Arje, MD, ACS, 777 Third Ave, New York, NY 10017. g3-8/78

Dec 5-9: *Fluid and Electrolyte Balance, Hypertension and Renal Disease,* American College of Physicians Postgraduate Course, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Ill. AMA-PRA Category I credit approved. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

June 12-July 9

Blood Components & Their Application, with Harold A Oberman, MD, Professor of Pathology, Director, Blood Banks and John A Penner, MD, Professor of Internal Medicine, Director, Coagulation Unit both at the University of Michigan Medical Center, Ann Arbor, Michigan. This program is co-sponsored by the Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical Center for Category 1 credit and accepted by the AAFP for Prescribed credit.

July 10-Aug 6

The Five Phases of Acute Myocardial Infarction, with J O'Neal Humphries, MD and Bernadine H Bulkley, MD both of the Johns Hopkins Hospital and School of Medicine, Baltimore, Maryland. This four-part telecourse is co-sponsored for Category 1 credit by the American Heart Association and is accepted for Prescribed credit by the AAFP.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

1978 AMA

Jun 17-22: 127th Annual Convention, St Louis, Mo. Info: AMA Housing Bureau, c/o St Louis Convention & Visitors Bureau of Greater St Louis, 500 North Broadway, St Louis, Mo 63102; or Ms Debbie Sweet, AMA Public Relations, 535 North Dearborn, Chicago, Ill 60610; or phone 312/751-6601.

Meetings of the American COLLEGE OF SURGEONS

CLINICAL CONGRESSES

1978: Oct 16-20—San Francisco
1979: Oct 22-26—Chicago
1980: Oct 20-24—Atlanta

SPRING MEETINGS

1979: Apr 2-5—Denver
1980: Mar 24-27—Toronto

Info:
American College of Surgeons
55 Erie St East, Chicago, Ill
60611

NATIONAL MEDICAL SPECIALTY SOCIETIES

1978 Meeting Dates/Sites

Apr 24-26: American Academy of Neurology, Los Angeles.

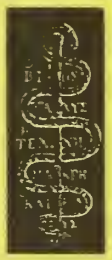
Apr 23-27: American Association of Neurological Surgeons, New Orleans.

Sep 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

American Society of Internal Medicine Future meetings:

Sept 26-29, 1978	Interim Meeting	Orlando, Florida
April 26-29, 1979	Annual Meeting	New Orleans, Louisiana
Sept 28-29, 1979	Interim Meeting	Las Vegas, Nevada
May 15-18, 1980	Annual Meeting	Washington, DC
Sept 26-27, 1980	Interim Meeting	San Diego, California
April 30—May 3, 1981	Annual Meeting	Denver, Colorado



CONTRIBUTIONS—CES FOUNDATION March 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1978.

Unrestricted

Anonymous; Ashland, Bayfield, Iron County Medical Auxiliary; Fond du Lac County Medical Auxiliary; Women's Auxiliary to the Medical Society of Milwaukee County; Outagamie County Medical Society Auxiliary; Auxiliary to the Racine County Medical Society; Waukesha County Medical Auxiliary; Women's Auxiliary to the Winnebago County Medical Society—*Voluntary Contributions*

Restricted

Women's Auxiliary to the Medical Society of Milwaukee County—*In Honor of President Elect Jules Levin, MD*
Health Insurance Association of America—*Cost Containment Program*
CIBA-GEIGY Corporation—*Guest Speakers Fund*
Appleton Family Practice Associates—*Medical Students Summer Externship Program*
Trempealeau, Jackson, Buffalo County Medical Society Auxiliary—*Aesculapian Society*
Membership Dues—*Aesculapian Society*

Memorials

State Medical Society—*Frederick C Heinan, MD; Gilbert F Mueller, MD*
Dr-Mrs Robert T Schmidt—*Mrs Floyd Collins; Myrtle Cotts (Brown County Loan Fund)*
Mr-Mrs Richard Stafford—*Mrs Lillian Tipple*
Grant County Medical Society—*Mrs HW Carey* ■

Lifesaving Partnership... Against Cancer Quackery

The anguish associated with cancer is compounded by the cancer quack. False hopes—harmful delays—devastating expenses—deceptive diagnoses—loss of life—these are hazards facing the cancer patient desperate enough to seek a cancer quack.

The problem: how to divert the patient from this tragic encounter.

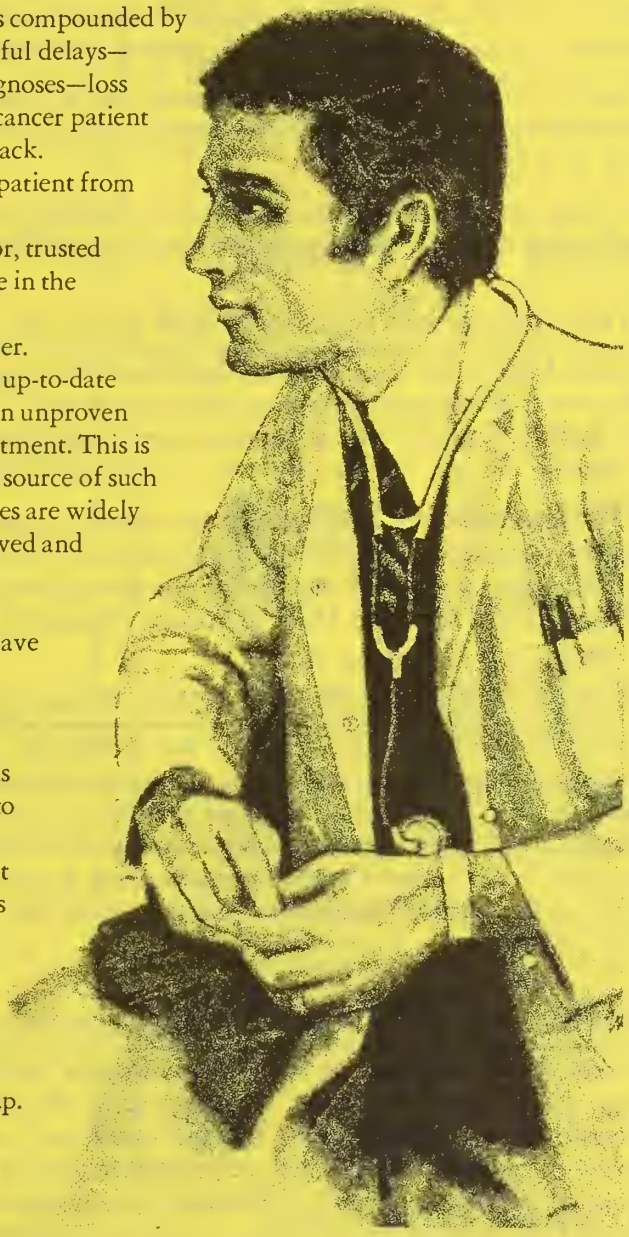
As medical guide, family counselor, trusted friend—you, *doctor,* play a major role in the fight against cancer quackery.

We are here to serve as your partner.

Our National Office maintains an up-to-date central clearinghouse for materials on unproven methods of cancer diagnosis and treatment. This is a unique operation and the principal source of such information in the country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.

To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has helped to inspire some 20 states to enact or consider legislation against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of laws in effect, are available through our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership.



American Cancer Society

American Cancer Society—Wisconsin Division, 611 North Sherman Ave, Madison, Wis 53704
American Cancer Society—Milwaukee Division, 6401 West Capitol Drive, Milwaukee, Wis 53216

COST CONTAINMENT CONFERENCE ATTRACTS PHYSICIANS

A conference examining the physician's role in the area of containment of medical care costs drew over 100 participants on April 13 at the SMS Annual Meeting. During the program, physicians were surveyed as to the cost containment in their own practices. Here are some of the survey results:

- About 90 percent of the physicians polled felt physicians have a responsibility to cut care costs wherever it is feasible; however, only four percent of the doctors receive a copy of the bills that hospitals send to their patients. Only 11 percent said they review the hospital charges with the patient.
- About two-thirds of the physicians said that at least once in 1978, and in many cases more often than that, they treated outside the hospital a medical problem that two years ago they would have treated with hospitalization.
- The large percentage of physicians—three-fourths—reported that they make a point of prescribing generic drugs in those instances where they believed there was no difference in quality.

MAY MARKS BEGINNING OF NEW SMS HEALTH COLUMN

Beginning May 1, the State Medical Society of Wisconsin's Communications Department will provide all Wisconsin newspapers with a weekly column on a variety of health subjects. The column, entitled, HEALTH CARING, will be authored by Victor S Falk, Jr, MD, Edgerton. Doctor Falk has been the Medical Editor of the *Wisconsin Medical Journal* since 1962.

HEALTH CARING evolved to fill a need expressed by many consumers to have more information about prevention of disease and illness and systems on how to stay healthy and maintain positive lifestyles. Suggestions about future topics for the column are welcome. Doctor Falk may be contacted by writing him at the State Medical Society offices, PO Box 1109, Madison, Wisconsin 53701.

SEMINARS ON MEDICATIONS FOR LONG-TERM CARE PATIENTS

The Wisconsin Health Care Review, Inc (WHCRI), will present statewide seminars in June on the administration and documentation of medications for long-term care residents and the intricacies of levels of care determinations. These seminars, of special interest to physicians involved in long-term care (medical directors, attending physicians), are scheduled for: Tuesday, June 6, Madison; Wednesday, June 7, Eau Claire; Thursday, June 8, Green Bay; and Friday, June 9, Milwaukee. To register, or for further information, contact: WHCRI, 330 East Lakeside St, Madison, WI 53715, 608/257-6781.

NEW TIME PERIOD FOR CME CREDIT REQUIREMENTS

The Legislature's passage of the Budget Review Bill (Assembly Bill 1220) in March 1978 has changed the present three-year, 45-credit hour requirement for Wisconsin physicians' completion of continuing medical education (CME) credit to a new, two-year, 30-credit hour requirement. Wisconsin physicians, in making their applications for reregistration must now "submit proof of attendance at and completion of continuing medical education programs or courses of study approved for at least *30 hours* of credit by the (Medical Examining) Board within *two calendar years* preceding the calendar year of which the registration is effective." Physicians are to note that this change *does not* increase the CME requirement that they must fulfill for reregistration in Wisconsin; it only changes the time period in which they must file proof of CME credit to the State Department of Regulation and Licensing. ■

STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

OFFICERS OF THE SOCIETY

PRESIDENT: *Jules D Levin, MD,* Milwaukee
PRESIDENT-ELECT: *Darold A Treffert, MD,* Winnebago
SECRETARY-GENERAL MANAGER: *Earl R Thayer,* Madison
TREASURER: *Eugene J Nordby, MD,* Madison
SPEAKER: *Albert J Motzel Jr, MD,* Waukesha
VICE-SPEAKER: *Duane W Taebel, MD,* LaCrosse
PAST PRESIDENT: *Roy B Larsen, MD,* Wausau

THE COUNCIL

CHAIRMAN: *Paul S Haskins, MD,* River Falls
VICE-CHAIRMAN: *Timothy T Flaherty, MD,* Neenah

FIRST DISTRICT: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha counties
John P Mullooly, MD, Milwaukee
Paul G LaBissoniere, MD, Wauwatosa
Wayne J Boulanger, MD, Milwaukee
Daniel K Schmidt, MD, Milwaukee
John J Foley, MD, Menomonee Falls
William A Nielsen, MD, West Bend
Irwin J Bruhn, MD, Walworth
Carl S L Eisenberg, MD, Milwaukee
Elizabeth A Steffen, MD, Racine

SECOND DISTRICT: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk counties
Blake E Waterhouse, MD, Madison
Richard W Edwards, MD, Richland Center
William P Crowley, MD, Madison
Allen O Tuftee, MD, Beloit

THIRD DISTRICT: Buffalo, Crawford, Jackson, Juneau, LaCrosse, Monroe, Trempealeau, Vernon counties
Cornelius A Natoli, MD, LaCrosse

FOURTH DISTRICT: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood counties
John J Kief, MD, Rhinelander
Russell F Lewis, MD, Marshfield

FIFTH DISTRICT: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago counties
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1903 1978 75th ANNIVERSARY YEAR

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Journal Established 1903

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LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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State Medical Society of Wisconsin

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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On page 42, Resolution 28 was reported as being rejected along with an amendment proposed by Doctor Biek. This statement of House action was in error. The resolution was adopted with the amendment.

Resolution 28 was introduced by the Section on Public Health and Preventive Medicine. The resolution recommended that the State Medical Society request the Legislature to increase financial support for local health departments. Increased funding of health departments is needed to support preventive medicine and public health education efforts, the resolution noted.

The resolution was adopted with the following amendment: "That increased State funding of local health departments be sought to support preventive medicine and public health education efforts, provided that the State Medical Society Council can find and recommend appropriate ways to accomplish this so that financial incentives will assure greatly improved physician supervision and improved avenues of communication between public health nurses and private physicians."

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CORRECTION

On page 41 of the May 1978 issue of the *Wisconsin Medical Journal,* the caption under the picture in the article "Houghton Medical Student Award" should have read: Margaret Chen and Dr Robert T Cooney. Our apologies to Doctor Cooney who is president of the CES Foundation.

Bactericidal *in vitro* against susceptible strains*

IV/IM Dosage Flexibility

'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

***Respiratory tract infections** due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus*.

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli*, and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported. Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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NEONATAL SCREENING LAW NOW IN EFFECT

Wisconsin's new Neonatal Screening Law for Metabolic Disorders went into effect May 16 and requires that the attending physician perform a blood test on every newborn, prior to discharge from a hospital, for PKU, galactosemia, maple syrup urine disease, and neonatal hypothyroidism. At this time *only* the State Laboratory of Hygiene in Madison is authorized to provide for the tests specified above.

Kits for specimen collection are now available from the State Lab and can be ordered under the title: "Neonatal Screening Kit No. 9" in multiples of 10 for a cost of $6.00 per kit. These kits include instructions for the specimen collection, a return envelope, and an information sheet answering many of the common questions about the testing program.

Physicians with questions concerning the collection, the test procedures or the reporting procedures under this screening program should contact the State Laboratory of Hygiene office: (608) 262-1293, or the Clinical Chemistry Laboratory: (608) 262-3459. For questions concerning the implementation of this program in their individual hospitals, physicians should contact their hospital administration.

FTC RULES PATIENTS CAN GET EYE PRESCRIPTIONS

Ophthalmologists and optometrists must release a written prescription for eyeglasses or contact lenses to a patient who requests it, the Federal Trade Commission has ruled. The rule prohibits physicians and optometrists from charging patients extra for releasing the prescription, or from requiring patients to buy eyewear that the examiner dispenses.

According to FTC Chairman Michael Pertschuk: "The rule requires that all eye examiners give the consumer a copy of his or her prescription. Armed with this piece of paper, and the information sellers provide through advertisements, consumers will be better able to find the best combination of price and quality."

The American Association Of Ophthalmologists (AAO) has expressed concern that an ophthalmologist who released a contact lens prescription could be unfairly held liable for eye injuries due to improperly fitted lenses supplied by another ophthalmologist, optometrist, or optician.

DOH SHIFTS POSITIONS OF TOP STAFF

Wisconsin Division of Health Administrator Robert Durkin has reassigned three DOH assistant administrators to bureau directorships and eliminated the vacated positions. In an effort to cut costs, Charles J Fiss, former assistant administrator for health systems regulation was chosen to direct the Bureau of Quality Compliance. In addition, Frederick Miller, former assistant administrator for health systems development, was named head of the Bureau of Environmental Health, and Dr Edward Larkin, former assistant administrator for health services, was selected as head of the Bureau of Community Health. (See a more detailed listing of State Government agencies relating to areas of physician interest elsewhere in this BLUE BOOK issue of *WMJ*.)

LIABILITY PREMIUMS REDUCED 20%!

An aggregate 20% cut in state liability premiums was voted May 11 by the Board of Governors of the Wisconsin Health Care Liability Plan to be effective for premiums due after July 1, 1978. For several months the Society and its Physicians Alliance Division have urged this action.

The assessment for the Patients Compensation Fund will be approximately the same as the July 1977 rate. The Board agreed on a 6% assessment, raised 1% from the July 1977 rate to allow for the reduction in the Plan premiums. For a Class 6 premium (neurosurgeons, orthopedists, thoracic surgeons, and vascular surgeons) plus the Fund assessment, the savings would be slightly over $1800. For a Class 3 premium (general practitioners who perform major surgery, ophthalmology, proctology, cardiology, and emergency room physicians who perform major surgery), plus the Fund assessment, savings would be almost $700. ■

Blueprint for socialism

THOSE OF US WHO have interested ourselves in the 1978 Wisconsin State Health Plan, which has been promulgated by the Wisconsin Health Policy Council and the Division of Health, Department of Health and Social Services, are awe-struck by its magnitude. In a series of hearings held throughout the state, those physicians who attended were offered a 118-page summary of the over 700-page plan. It is vast in its scope and minute in its detail.

In the introduction to the plan is the statement "in simple terms, the goal is that everyone should have adequate health care and that it should not cost too much." The thrust of the planning mechanism has come from the Federal Government with a series of laws dating back to the Comprehensive Health Planning Act of 1966 at which time "health planning went public." A series of federal laws followed mandating the Health Systems Agencies (HSAs). From this reactor core of energy, the Wisconsin Health Policy Council has developed the current version of the Wisconsin State Health Plan.

What is upsetting to a physician reading the 118-page shortened version are the solutions to what the Health Planning Council regards as problems. While they acknowledge in many areas of the plan that available data do not justify their conclusions, they nevertheless make specific recommendations for solutions. Among them are determining numbers of obstetrical beds in Wisconsin communities, determining percentages of surgery that should be done on an ambulatory basis, determining what the fees should be for laboratory services, and recommending that all hospital radiologists and pathologists should be salaried. The plan also includes requesting the hospitals to restructure their statistical methods "in appropriate ways for use by the Health Systems Agencies." This will give the HSAs additional information so that they can increase their "data base." Undoubtedly this will allow them to develop further recommendations.

Physicians who are unaware of the magnitude of the Wisconsin State Health Plan should interest themselves in these developments.

What the plan projects is pure socialism. At no time is the private sector to be anything more than regulated. The rates and availability of medical services will be determined not by the providers but by the planners.

If the State Health Plan were to come to full fruition, it is a blueprint for socialized medicine in Wisconsin; no where in the plan is there any effort to do otherwise.

Those of you who are not interested in the plan may soon find that you are working for it.—RAM

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It doesn't always pay to advertise

AT THE ANNUAL MEETING in April the Council adopted an official State Medical Society position on physician advertising (see page 48). The Society does not have a policy prohibiting advertising by physicians except that such advertising may not contain information that is false, misleading or deceptive. Also, in the April issue of the *Wisconsin Medical Journal,* the Editorial Director produced an ode to the cod and a warning about unprofessional advertising.

The following is an example of the ridiculous extremes to which advertising can be carried. The Department of Registration and Education in Illinois suspended a chiropractor's license for violation of advertising restrictions in the Medical Practice Act. The chiropractor in August 1972 published a half-page advertisement in a suburban newspaper and placed copies of the ad in his office window. The ads offered free chicken, free refreshments and a free spinal x-ray, and condemned reliance on drugs. Two years later he attached advertising circulars to light posts, a traffic-control box and a mailbox near his office. He also attached circulars and business cards to his office window to be taken by passers-by.

His license was suspended for ninety days. However, a trial court ruled that the advertising restrictions of the Medical Practice Act violated the First Amendment. Finally the Illinois Supreme Court reversed the trial court's decision and said that the chiropractor's advertisements were not entitled to First Amendment protection and further that the advertisements were uninformative and misleading.

The American Medical Association has issued guidelines on both advertising and solicitation which might be helpful for physicians in determining the

appropriateness of advertising plans (see page 49). Actually, for an ethical physician there is little reason to advertise beyond the usual notice of starting his practice or association with a group, a change of office address or a small business card if this is a local practice.—VSF

"Zero-base" approach to committee proliferation

U S SENATOR FROM California S I Hayakawa (and English instructor at the University of Wisconsin in the 1930s) recently mailed out a report on health and education advisory committees. His three-fold purpose in sending out the list of committees within the Department of Health, Education, and Welfare was: (1) to help identify the committees in which physicians may have a professional interest; (2) to invite comment to appropriate agencies on the advisability of continuing each of these committees; and (3) to focus attention on the proliferation of government agencies which consume tax dollars. He stated that President Carter had issued a directive requiring that an annual review be made involving a "zero-base" analysis of all committees, conducted with the presumption that all committees should be abolished except those for which there would be a compelling need, which have truly balanced membership and which conduct their business as openly as possible.

Senator Hayakawa requests that physicians make honest and critical judgments and that recommendations be sent to appropriate HEW agencies. The problem is that most physicians in Wisconsin could hardly be considered qualified to comment on the complex bureaucracy within the department.

Here are some examples and questions of duplication. Within the Food and Drug Administration there are 57 committees and panels. One wonders if it is necessary to have an Anesthesiology Advisory

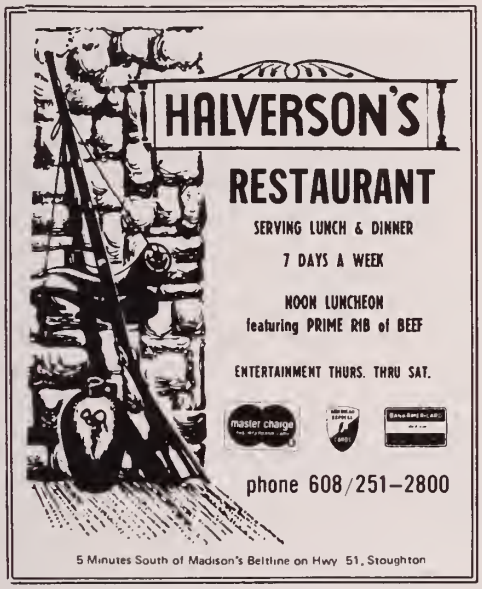
CONSENT FORMS FOR PHYSICIANS

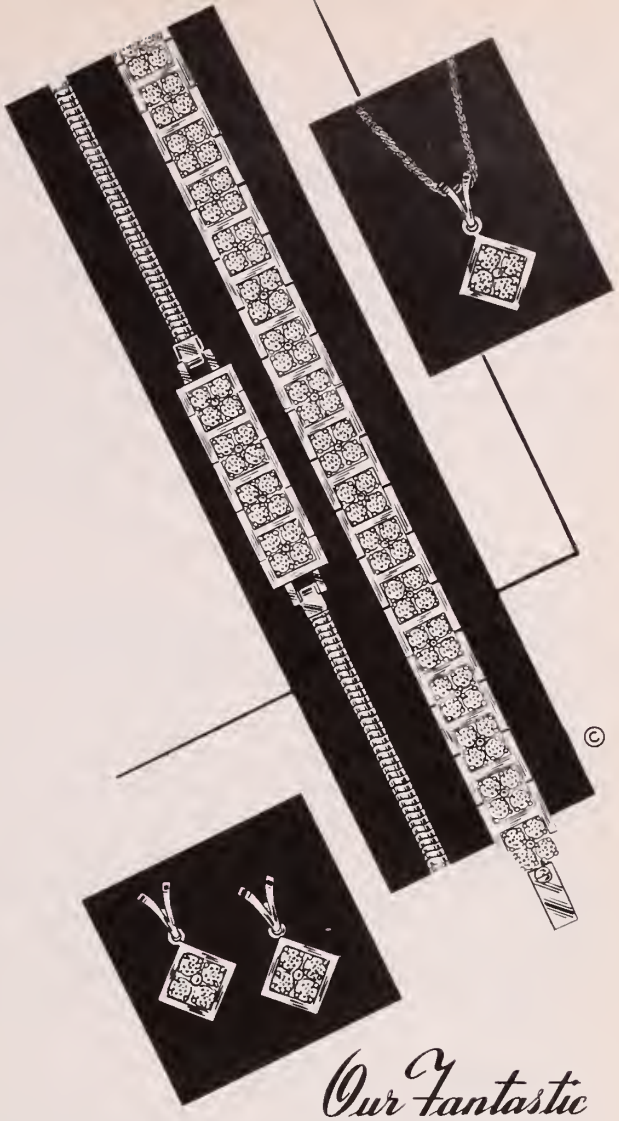
FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

Committee and an Anesthesiology Device Classification Panel. There also is a Dental Device Panel and a Panel on Review of Dentifrices and Dental Care Agents. There are Panels on Obstetrical and Gynecological Device Classification and on Review of Contraceptives and Other Vaginal Drug Products. There is an Ophthalmic Device Classification Panel and an Ophthalmic Drugs Advisory Committee and another called Panel on Review of Ophthalmic Drugs. Another two Panels are on the Review of Bacterial Vaccines and Bacterial Antigens and on the Review of Bacterial Vaccines and Toxoids. There is also a Board of Tea Experts and one can envision their conferences.

Even more mind boggling is the National Institutes of Health. Here there are 151 committees, councils, and sections. There are 16 committees devoted to cancer alone in addition to a National Cancer Advisory Board and the Presidents Cancer Panel. Who among us can say if the Committee on Cancer Immunobiology, The Committee on Cancer Immunodiag-





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nosis, and the Committee on Cancer Immunotherapy each deserves individual status or whether they could be consolidated.

In addition to the two agencies mentioned above there are an additional nine agencies within HEW.

Without denigrating the Department of HEW, the three long pages of committees does raise a question as to whether there is a compelling need for each and every one. If any one of you feels qualified to answer, Senator Hayakawa will be pleased to hear from you.—VSF

Trampoline trauma

At a recent meeting of the American Academy of Orthopedic Surgeons, a midwest orthopod called trampolining one of the most dangerous sports in the world.

He reported 34 cases of paralysis and three deaths. He also said he was successful in banning competitive trampoline events at 35 high schools in Indiana.

Trampolining is still required as a part of the physical education program in many Wisconsin schools. School administrators should be aware of the potential danger of this senseless bouncing up and down and of the tragedy of a teen-aged quadriplegic.—VSF

The peanut connection

President Carter's attack on the legal profession was closely followed by an unwarranted assault on organized medicine. Patrick Buchanan, a *New York Times* Special Features writer, described it as a "slanderous assault." Buchanan quoted the President as saying "when doctors organize into the American Medical Association their responsibility is to the welfare of doctors." This makes it sound as if the AMA was organized just yesterday to thwart the administration. The AMA has been in existence for over 131 years and can hardly be regarded as a Johnny-Come-Lately organization.

Buchanan went on to say that "if they (AMA) are organizing to fight the national health insurance scheme, which helped ruin British medicine and which Carter supports, they are fighting for better health for all of us. And what is wrong with doctors organizing to defend their legitimate interests? After all, peanut growers and peanut shellers organize to keep themselves subsidized by taxpayers. And when the maritime union organized to rip off the American consumer with the Cargo Preference Act, they had the enthusiastic support of one populist who lives at 1600 Pennsylvania Avenue."

Shortly after the attack on medicine, it was announced that President Carter decided to mount a massive campaign this year on the behalf of a national health insurance program that would provide universal and mandatory coverage for all citizens. White House officials say privately that Carter has decided to launch an all-out push for the controversial legislation before the end of the year, despite the enormous cost of such a plan.

All of which makes it appear that the assault on the AMA immediately followed by the push for a full United States health plan is much more of a connection than a coincidence.—VSF

Seat belts

Recently the Associated Press published a report from Acting Governor Martin Schreiber. In August 1977 on a single weekend 27 persons died on Wisconsins highways. This was the highest holiday weekend traffic toll in the history of the state.

Governor Schreiber commissioned a study of multiple fatality traffic accidents in Wisconsin in the latter part of 1977. One of the revelations of this study was the startling figure that only seven of the 118 drivers and passengers involved in the multiple fatal automobile accidents were wearing seat belts. Although not all of the victims wearing seat belts survived, many more would have had they been wearing safety belts.

Although it would be gruesome, it would also be very impressive if the citizens of Wisconsin could be in the Emergency Room of any hospital when the gory results of highway accidents are brought in. Routine questioning of the accident victims who are able to respond or the ambulance personnel who retrieved them, includes whether or not seat belts were in use. The almost universal negative response is indeed depressing.

It takes only a second or two to buckle up a seat belt and a shoulder strap. The time it takes to do this is infinitesimal compared with the hours of agony to the victim and his family, the prolonged hospitalization, the possibility of scars and deformities and even fatal outcome.

Cars are equipped with seat belts, so for heaven's sakes, use them! —VSF ■

BROCHURES AVAILABLE

- **SMS—An organization on the move!**—An "envelope stuffer" brochure which explains the Society's efforts in such areas as professional liability, political action, Medicaid, communications, continuing medical education, negotiations with third parties, benefits and services of SMS membership.
- **To Your Good Health**—An SMS "envelope stuffer" brochure which explains why medical costs have increased and how individuals can reduce medical bills by staying healthy.

HAVE YOU BEEN CALLED LATELY?

or, What's the Latest on the Patients Compensation Panels?

In 1975 MANDATORY pre-trial screening panels were legislated. See article on page 41, "You Are Being Sued for Malpractice, or What the Physician Should Know About Malpractice Litigation," for a description of the panel process. A pamphlet including information on the Patients Compensation Panels is also available from the State Medical Society's Physicians Alliance on request, "So You've Been Sued . . . Now What?"

Do I have to serve as a panel member if I am called?

Yes, by law, unless the administrator of the panels excuses you for "good cause." *Good cause* is interpreted as meaning: (1) a conflict of interest, (2) a schedule conflict, such as operative, emergency, out of the state or country, or a pre-arranged lecture series, etc, (3) strong moral, ethical or religious beliefs, and (4) if the medical issue is one with which the physician is not familiar.

How much of my time will be required?

Physicians are appointed to the Formal Panel (5-members) for a period of six months. Physicians also may be appointed to the Formal Panel, as well as the Informal Panel (3-members) on a case-by-case basis. You will be expected to review the specifics of the case, such as medical records, depositions, etc, before the panel hearing. These records are usually sent two to four weeks prior to the hearing date. The physician panel member also may be asked to alert the panel of other medical experts who should be consulted. The hearing, with all parties present, averages two days. Informal Panels usually take one day, plus the panel deliberation of approximately 3 to 5 hours. Formal Panels are often longer; four days may be required. In Milwaukee, meetings are held evenings or weekends if possible. You may be required to travel to another city for the hearing.

What if I don't want to serve on the panel?

The Panel Administrator (through the Supeme Court of Wisconsin) does have sanction applicable to civil actions (Formal Panels) and could hold a physician in contempt for non-appearance or tax the physician for the costs of the panel hearing. However, both the State Medical Society and the Panel Administrator are interested in maintaining a positive atmosphere in this relatively new approach to resolving professional liability disputes. The Society urges a cooperative attitude. And to date, results are encouraging. As of May 1978, only 5 out of about 105 cases have been filed in court after a panel determination.

What compensation will I receive for my time?

As a panel member, you will be paid $75 per day for attendance at the hearing, plus travel expenses. Panels can call their own expert witnesses, if this is necessary in addition to panel expertise. Expert medical witnesses are paid according to their regular fee-for-service. While the availability of this medical expertise has been viewed by some as a relatively inexpensive "fishing expedition" for attorneys and their clients, sometimes this second medical opinion settles the issue to the patient's and attorney's satisfaction.

Why me?

Who else? If you would like more information, call or write the SMS Physicians Alliance, PO Box 1109, Madison, WI 53701; telephone toll-free: 1-800-362-9080.

Position Available: Requires a thorough knowledge of tax laws, real estate, accounting procedures, insurance, finance and investments. Candidate must be able to collect and inventory all property, have all property appraised, collect income and rents, carry appropriate insurance, contest all claims believed invalid, pay all expenses, render accurate accounts and make distribution under court approval. Must be impartial. Should be willing to work long hours and accept risk of personal financial liability for errors.

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THE ANNUAL "BLUE BOOK" ISSUE

SINCE 1924 the *Wisconsin Medical Journal* has published annually a "Blue Book" edition containing a variety of articles relating to medicolegal, socio-economic matters of direct concern to the physician in his relationship to patients, hospitals, government agencies, and others on the "health team."

The "Blue Book" is a useful reference book. Physicians are urged to keep the Journal handy at all times.

Significant Legislation

• Certificate of Need • Continuing Medical Education • Medical Assistance Changes • Frivolous Lawsuits

DURING THE 1977 session of the Wisconsin Legislature, a number of significant changes were enacted in state laws which directly affect physicians. In addition, a number of changes in the Wisconsin Administrative Code were adopted by a variety of state agencies. For your reference, these laws and code changes are reprinted here in order for you to have them available for quick reference.

The Physicians Alliance Division of the State Medical Society, through the personal involvement of hundreds of physicians throughout the state, was able to dramatically affect the substance of most of these changes. Several of these changes, in particular the 1977 Certificate of Need law, as well as important changes in the Medical Malpractice law, were developed by the Division and the physician commissions and committees which it serves.

Questions regarding these new laws may be directed to the Alliance staff at PO Box 1109, Madison 53701, or by calling **toll-free** 1-800-362-9080.

CERTIFICATE OF NEED

Chapter 29, Laws of 1977
(Pertinent excerpts)

- - -

150.02 Applicability. (1) This subchapter applies without limitation to all persons who intend to engage in any of the following activities by or on behalf of a health care institution:

(a) The lease, construction or purchase of a health care institution.

(b) A substantial change in health service.

(c) A change in bed capacity, not including temporary increases in bed capacity, except that transfers of beds between services which do not involve specialized services are exempt unless the transfer involves more than 10 beds or more than 10% of the institution's capacity, whichever is less, over a 2-year period.

(d) An expenditure, not covered by par. (b), of more than $100,000 for a single piece of clinical equipment, or of more than $150,000 for 2 or more pieces of related clinical equipment, if there is an expenditure for one of the pieces of more than $100,000. Two or more pieces of clinical equipment that can perform their normal functions only when used simultaneously or when connected to each other constitute a single piece of equipment for purposes of this subsection. Pieces of equipment are related if the diagnostic or therapeutic services provided with the equipment are normally provided to the same individual as a clinical service.

(e) Any capital expenditure not covered by pars. (a) to (d).

(lm) The proposed lease or purchase of an existing health care institution is not subject to this subchapter if the institution will continue to operate under the same category of license or permit as the institution possesses prior to the date of the proposed lease or purchase and none of the other activities described in sub. (1) take place in conjunction with such lease or purchase.

(2) *This subchapter also applies without limitation to all persons who intend to engage in any of the following activities by or on behalf of an independent practitioner, partnership, unincorporated medical group or service group as defined in s. 180.99:*

(a) An expenditure for a single piece of clinical equipment of more than $100,000, or

(b) An expenditure for clinical equipment which exceeds $150,000 for 2 or more pieces of related equipment, if there is an expenditure for one of the pieces of more than $100,000. Two or more pieces of clinical

equipment that can perform their normal functions only when used simultaneously or when connected to each other constitute a single piece of equipment for purposes of this subsection. Pieces of equipment are related if the diagnostic or therapeutic services provided with the equipment are normally provided to the same individual as a clinical service.

(3) No person may divide a project to avoid the requirements of this subchapter. When any person acquires under a lease or comparable arrangement, or through donation, any health facility or part thereof, equipment for a facility or clinical equipment which would have been subject to this subchapter had it been purchased, that acquisition is subject to this subchapter.

(4) The department shall, if permitted by the secretary of health, education and welfare, exempt from the formal review requirements, projects which meet the criteria listed below. All requests for such a nonsubstantive review by the applicant or the substate health planning agency must be made in writing to the department. The department, after consultation with the appropriate substate health planning agency, shall make a determination within 15 days after receipt of a written request. The department shall issue a certificate on all approved projects declared nonsubstantive within 20 days of this determination. A project which is determined to be subject to review shall be declared nonsubstantive if it meets one of the following criteria:

(a) A one-time capital expenditure of less than $10,000.

(b) Capital expenditure projects developed pursuant to a plan of correction for code deficiencies previously approved by the department.

(c) Capital expenditure projects which are required to remedy an emergency situation detected not more than 30 days prior to the request for a nonsubstantive review determination and which threatens the safety of patients or the ability of the institution to remain in operation.

(d) Replacement of clinical equipment with equipment of similar capability if the equipment is included in the facility's annual capital expenditure budget or plan.

(5) The department may promulgate by rule additional criteria which, if approved by the secretary of health, education and welfare, may be used to declare a project nonsubstantive.

150.03 Compliance required for licensing and approval. No license may be issued or renewed nor may approval be granted for any health care institution which fails to comply with this subchapter.

150.04 Initial notification requirement. No person intending to undertake a project which is subject to this subchapter may engage architectural or professional consultation or fund-raising services with respect to the project other than feasibility studies until it has notified the department and the substate health planning agency for the area in which the project will be located of its intention to engage such services. The form and content of the notification of intent shall be established by rule by the department.

150.05 Certificate of need requirement. (1) No person may enter into an obligation in support of a project described in s. 150.02 or engage in activities described in that section unless the obligation or activities are authorized by a valid certificate of need.

(2) The department shall prescribe the form to be used in applying for certificates of need and for applying for renewal, modification or amendment. The department shall consult with the substate planning agencies and appropriate governmental and affected parties prior to prescribing the form of the application. A statement of the applicable rules and procedures to be followed in the review of an application shall be issued with each application form. The department may require no information under this section which is not prescribed and published as being required information.

(3) No person may apply for a certificate of need unless that person submits proof of consultation with the substate health planning agency for the area in which the project is to be located relative to need for the project, including plans, specifications and design of the project. It is the responsibility of the substate health planning agency within the area the project is to be located to notify other agencies potentially impacted by the proposed project. Proof of such consultation shall be submitted in a form prescribed by rule by the department.

(4) An application for a certificate of need shall be filed jointly with the department and the appropriate substate health planning agency.

150.06 Review process. (1) The appropriate substate health planning agency shall review each application for a certificate of need in accord with standards and procedures established under s. 150.07, and for consistency with locally developed plans and standards, and shall submit its comments thereon to the department within 60 days after receipt of a complete application. The comments may include a recommendation to approve the application without modifications, to approve the application subject to specified modifications or to reject the application. Suggested modifications, if any, shall relate directly to the project under review.

(2) (a) The appropriate substate health planning agency shall, during the course of its review, provide an opportunity for a public meeting at which interested persons may introduce testimony and exhibits. Public meetings required by this subsection shall be conducted according to rules promulgated by the department.

(b) Any interested person may file written comments and exhibits concerning a proposal under review with the appropriate substate health planning agency and the department.

(c) For the purposes of this subchapter, the department is exempt from the requirements of s. 227.075.

(3) The department shall, except as provided in sub. (4), issue a certificate of need with or without any specified modifications or reject the application within 30 days after receiving the comments on the application from the substate health planning agency. If the department fails to act within such period, the failure to act shall constitute rejection of the application. Modifications shall relate directly to the project and may not constitute conditional approval based on the addition, alteration or termination of other services or facilities provided by the health care institution requesting the certificate.

(4) If the decision by the department contradicts the recommendations of the substate health planning agency, the department shall issue a certificate of need 30 days after notification of approval has been given, if no appeal has been made under s. 150.09. The department may promulgate by rule criteria by which certificates of need for contested cases will be withheld for 30 days to permit appeals to be made under s. 150.09.

150.065 Extended review. The department shall promulgate rules establishing criteria for determining when it would not be practicable to complete a review within 90 days from receipt of a completed application. If the department finds that these criteria are met for a particular project, it shall extend the review period for a period not to exceed 60 days, except with the consent of the applicant, and provide notice of such extension to all affected persons. The time limitations in s. 150.06 (2) shall be modified accordingly.

150.067 Findings. The department shall, within 15 days after it approves or rejects an application under s. 150.02, provide in writing to the applicant, to the appropriate substate health planning agency and, upon request, to affected persons the findings and conclusions on which it based its decision, including but not limited to the criteria under s. 150.07 used by the department in making such decision.

150.07 Review criteria and standards. (1) The department shall by rule promulgate and utilize, as appropriate, specific criteria for conducting its reviews under the subchapter including but not limited to the following general considerations:

(a) The relationship of the health services being reviewed to the applicable health systems plan and annual implementation plan adopted under section 1513 (b) (2) and (3), respectively, of P.L. 93-641.

(b) The relationship of services reviewed to the long-range development plan, if any, of the person providing or proposing the services.

(c) The need that the population served or to be served by the services has for the services.

(d) The availability of less costly or more effective alternative methods of providing the services.

(e) The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the new institutional health service.

(f) The relationship of the services proposed to be provided to the existing health care system of the area in which the services are proposed to be provided.

(g) The availability of resources, including but not limited to health manpower, management personnel, and funds for capital and operating needs for the provision of the services proposed to be provided and the availability of alternative uses of those resources for the provision of other health services.

(h) The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services.

(i) Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service area in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics and specialty centers.

(j) The special needs and circumstances of health maintenance organizations for which assistance may be provided under Title XIII of the public health services act. Such needs and circumstances include the needs of and costs to members and projected members of the health maintenance organization in obtaining health services and the potential for a reduction in the use of inpatient care in the community through an extension of preventive health services and the provision of more systematic and comprehensive health services.

(k) The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

(L) In the case of a construction project, the costs and methods of the proposed construction, including the costs and methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project.

(2) Each substate health planning agency shall adopt and utilize as appropriate specific criteria for conducting its reviews under this subchapter, including but not limited to the general considerations specified in sub. (1) (a) to (L).

(3) All standards established by the department shall distinguish between rural, urban and metropolitan areas as defined by population density to the extent that variable standards will benefit the development of the most appropriate health care system for the service area. All such standards shall be subject to review and comment by substate health planning

agencies, public meetings in each substate health planning area, and review by the statewide health coordinating council prior to use in reviewing certificate of need applications.

(4) Before issuing a certificate of need, the department shall consider, in accordance with the appropriate criteria of sub. (1), the need for health care institutions, services related thereto and clinical equipment as projected in various state plans prepared annually by substate health planning agencies and state agencies, including but not limited to the medical facilities construction and modernization program, mental health centers plan, programs for facilities and services for the mentally retarded, rehabilitation services program, the alcoholic and drug abuse programs, and special studies, surveys and information. Information submitted by a religious organization in support of its application, demonstrating a desire on the part of persons in the area to be served by the facility to be cared for in an institution sponsored by that particular religious organization, shall be a significant consideration in determining the need for that facility. This information may consist of waiting lists substantiated by verified applications for admission to the institution, surveys and any other forms of information which the state health planning agency requires.

150.08 Forfeiture. Any person who violates this subchapter or any rule adopted under this subchapter shall forfeit not less than $100 nor more than $1,000 for each such offense. Each day of violation constitutes a separate offense.

150.085 Rehearing. Any affected person may request a rehearing under s. 227.12 on the basis of the grounds specified in s. 227.12 (3) or such other grounds as the department may specify by rule.

150.09 Appeals. The department shall promulgate rules establishing procedures by which any person applying for a new, modified or amended certificate of need or a substate health planning agency may appeal a decision by the department. The procedures shall include an opportunity for an appeal to an independent hearing officer, appointed by the governor under s. 252.075 (3). In an appeal of a decision to deny a certificate of need, the department shall bear the burden of proving that the project fails to meet the criteria specified in its written findings under s. 150.067. In an appeal of a decision to grant a certificate of need, the person appealing that decision must prove that the project fails to meet such criteria. The appeals shall be conducted in the manner described in s. 227.20, except that findings, conclusions and the decision resulting from the hearing shall, to the extent the determinations of the department are reversed or modified, constitute the determinations of the department.

150.10 Validity of a certificate. A new, modified or amended certificate of need is valid for a period of one year from the date of issuance and may be renewed at the expiration of this period. The certificate of need may be renewed one or more times for periods of up to one year only if evidence of substantial and continuing progress on the project is submitted or if the applicant demonstrates a commitment to obligate for the proposed project within the extension period. The department may establish rules to assure timely completion of the project.

150.12 Fees. Persons applying for certificates of need shall pay application fees according to the schedule in this section.

(1) No fee may be charged for any nonsubstantive project under s. 150.02 (3), any project whose total cost is less than $10,000 or the purchase of single pieces of replacement equipment.

(2) For all other expenditures the fee shall be 0.2% of the estimated project cost with a maximum fee of $15,000 and a minimum fee of $100.

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GENETIC TESTING

In spite of the strong objections of the Society, the Legislature enacted 1977 Assembly Bill 299, which became Chapter 160, Laws of 1977. This act adds a list of "diseases" to the "PKU" testing law, enacted in the early 1960s. While the Society is contesting the method of implementation of this law by the Department of Health and Social Services at the time of this writing, the law went into effect as scheduled on May 16, 1978:

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15.197 (3p) COUNCIL ON INFANT HEALTH SCREENING. There is created in the department of health and social services a council on infant health screening which shall consist of 2 persons chosen to represent the public who are not health care providers nor associated with the delivery of health care, 3 physicians experienced in the subject of metabolic disorders and one person appointed by the secretary of health and social services.

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15.197 (3p) of the statutes is repealed.

146.02 (title) **Tests for metabolic disorders.** (1) (title) BLOOD TESTS. The attending physician shall cause every infant born in each hospital or maternity home, prior to its discharge therefrom, to be subjected to a test for phenylketonuria, *galactosemia, maple syrup urine disease, neonatal hypothyroidism* and such ~~other~~ causes of ~~mental retardation~~ *metabolic disorders* under sub. (2) as the department directs.

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146.02 (1m) URINE TESTS. The department may establish a urine test program to test infants for causes of metabolic disorders. The department may establish the methods of obtaining urine specimens and testing such specimens, and may develop and provide materials for use in the tests. No person may be required to participate in the programs developed under this subsection.

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146.02 (2) (title) PERFORMANCE OF TESTS. The tests to be performed shall be determined by the department and shall be performed in such ~~regional~~ laboratories as the department approves for this purpose, in accordance with rules prescribed by the department. *The department, in making any specifications as to laboratories in which tests required under subs. (1) and (1m) will be performed, shall take into consideration before specifying such laboratories the test costs to the financially responsible private parties and to the state under each of the following options:*

(a) Specifying a single testing laboratory;

(b) Specifying several laboratories on a geographic or other basis; or

(c) Specifying all laboratories, public and private, to process the required tests.

(3) (title) EXCEPTIONS. This section shall not apply if the parents *or legal guardian* of the child object thereto on the grounds that the test conflicts with their religious tenets and practices. *No tests may be performed under sub. (1) or (1m) unless the parents or legal guardian are fully informed of the purposes of testing under this section and have been given reasonable opportunity to object as authorized in this subsection or in sub. (1m) to such tests.*

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146.02 (4) CONFIDENTIALITY OF TESTS AND RELATED INFORMATION. The laboratory shall provide the test results to the physician, who shall advise the parents or legal guardian of the results. No information obtained under this section from the parents or guardian or from specimens from the infant may be disclosed except for such information as the parent or guardian consents to be released, and except for use in statistical data compiled by the department without reference to the identity of any individual.

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146.025 Council on infant health screening. The council on infant health screening shall study the feasibility of testing of newborn infants for the purpose of discovering metabolic disorders. The council shall advise the department on the development and implementation of screening plans. The council shall report its findings on a yearly basis to the legislature and to the medical examining board.

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Effective date. This act shall take effect on the 181st day after its publication, except that SECTION lm of this act shall take effect on the first day of the 48th month after the publication of this act.

PROFESSIONAL LIABILITY

Because of the substantial efforts of state physicians, Assembly Bills 705 and 237 were enacted early in 1978. Assembly Bill 705 was developed by a special study committee of the Legislature during the summer of 1976. It serves to lower the statute of limitations for minors in medical malpractice cases in order to reduce insurance premiums and to substantially reduce the rather long period of time for which physicians would be liable for actions brought by patients. Assembly Bill 705 became Chapter 390, Laws of 1977:

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893.235 Health care providers; minors actions. Any person under the age of 18, who is not under disability by reason of insanity, developmental disability or imprisonment, shall bring an action to recover damages for injuries to the person arising from any treatment or operation performed by, or for any omission by, a person who is licensed, certified, registered or authorized to practice as a health care provider under state law within the time limitation under s. 893.205 (1) or by the time that person reaches the age of 10 years, whichever is later. That action shall be brought by the parent, guardian or other person having custody of the minor within the time limit set forth in this section.

* * *

In addition, physicians have charged that many malpractice actions are "frivolous," in that the suits are designed to harass the physician and to force out of court settlements. Assembly Bill 237 is a "general frivolous lawsuit" bill which became Chapter 209, Laws of 1977:

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814.025 Costs upon frivolous claims and counterclaims. (1) If an action or special proceeding commenced or continued by a plaintiff or a counterclaim, defense or cross complaint commenced, used or continued by a defendant is found, at any time during the proceedings or upon judgment, to be frivolous by the court, the court shall award to the successful party costs determined under s. 814.04 and reasonable attorney fees.

(2) The costs and fees awarded under sub. (1) may be assessed fully against either the party bringing the action, special proceeding, cross complaint, defense or counterclaim or the attorney representing the party or may be assessed so that the party and the attorney each pay a portion of the costs and fees.

(3) In order to find an action, special proceeding, counterclaim, defense or cross complaint to be frivolous under sub. (1), the court must find one or more of the following:

(a) The action, special proceeding, counterclaim, defense or cross complaint was commenced, used or continued in bad faith, solely for purposes of harassing or maliciously injuring another.

(b) The party or the party's attorney knew, or should have known, that the action, special proceeding, counterclaim, defense or cross complaint was without any reasonable basis in law or equity and could not be supported by a good faith argument for an extension, modification or reversal of existing law.

* * *

Assembly Bill 704

Finally, Assembly Bill 704, a general "housekeeping" bill regarding the state malpractice system, was enacted on October 31, 1977. Copies of this act are available upon request from the Physicians Alliance Division at the State Medical Society.

CONTINUING MEDICAL EDUCATION

Since the enactment of the Malpractice Act in 1975, several changes have been suggested in the continuing medical education/licensing requirements for physicians.

The 1977 Budget Review Bill alters the current licensing structure for physicians by changing that system to a two-year license. In addition, starting with the license renewal period: 1982-1983, physicians must complete *30* hours of continuing education in approved courses during the two calendar years preceding the license renewal period (*i.e.*, 1980-1981). The actual statutory language appears below:

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448.13 (title) BIENNIAL TRAINING REQUIREMENT. Each physician shall, in each ~~3rd~~ *2nd* year at the time of application for a certificate of registration under s. 448.07, submit proof of attendance at and completion of continuing education programs or courses of study approved for at least ~~45~~ *30* hours of credit by the board within the ~~3~~ *2* calendar years preceding the calendar year for which the registration is effective. The board may waive this requirement if it finds that exceptional circumstances such as prolonged illness, disability or other similar circumstances have prevented a physician from meeting the requirement.

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MEDICAL ASSISTANCE PROGRAM

In an attempt to recodify appropriate language in the Medical Assistance Program, the Wisconsin Department of Health and Social Services sought and received direction from the 1977 Legislature in the areas of Medical Assistance fraud and abuse, as well as privileged communications between physicians and Medical Assistance recipients:

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49.49 MEDICAL ASSISTANCE OFFENSES. (1) FRAUD. (a) *Prohibited conduct.* No person, in connection with a medical assistance program, may:

1. Knowingly and wilfully make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment.

2. Knowingly and wilfully make or cause to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.

3. Having knowledge of the occurrence of any event affecting the initial or continued right to any such benefit or payment or the initial or continuing right to any such benefit or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

4. Having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and wilfully convert such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

(b) *Penalties.* Violators of this subsection may be punished as follows:

1. In the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing by that person of items or services for which medical assistance is or may be made, a person convicted of violating this subsection may be fined not more than $25,000 or imprisoned for not more than 5 years or both.

2. In the case of such a statement, representation, concealment, failure, or conversion by any other person, a person convicted of violating this subsection may be fined not more than $10,000 or imprisoned for not more than one year in the county jail or both.

(c) *Damages.* If any person is convicted under this subsection, the state shall have a cause of action for relief against such person in an amount 3 times the amount of actual damages sustained as a result of any excess payments made in connection with the offense for which the conviction was obtained. Proof by the state of a conviction under this section in a civil action shall be conclusive regarding the state's right to damages and the only issue in controversy shall be the amount, if any, of the actual damages sustained. Actual damages shall consist of the total amount of excess payments, any part of which is paid by state funds. In any such civil action the state may elect to file a motion in expedition of the action. Upon receipt of

the motion, the presiding judge shall expedite the action.

(2) KICKBACKS, BRIBES AND REBATES. (a) *Solicitation or receipt of remuneration.* Any person who solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a medical assistance program, or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a medical assistance program, may be fined not more than $25,000 or imprisoned for not more than 5 years or both.

(b) *Offer or payment of remuneration.* Whoever offers or pays any remuneration including any kickback, bribe, or rebate directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a medical assistance program, or to purchase, lease, order, or arrange for or recommmend purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under a medical assistance program, may be fined not more than $25,000 or imprisoned for not more than 5 years or both.

(c) *Exceptions.* This subsection shall not apply to:

1. A discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a medical assistance program.

2. Any amount paid by an employer to an employe who has a bona fide employment relationship with such employer for employment in the provision of covered items or services.

(e) *Medical assistance offenses.* The treatment of section 49.49 (1) and (2) of the statutes by this act shall apply to acts occurring and statements or representations made on or after the effective date of this act.

ABORTION

Perhaps the most emotional issue of the 1977 Session was a successful attempt by some legislators to eliminate public funding for abortions. Signed into law on April 21, 1978, the State of Wisconsin now refuses to pay for abortions in the Medical Assistance and general Welfare system.

Chapter 245, Laws of 1977:

SECTION 1. **Legislative findings, policy declaration; construction of act.** The legislature finds that the state of Wisconsin throughout its entire history has declared the performance of nontherapeutic abortions to be illegal and a crime because they destroy human life, but that since the U.S. supreme court's decisions of January 22, 1973, *(Roe v. Wade,* 410 U.S. 113 and *Doe v. Bolton,* 410 U.S. 179) abortions are being performed on demand and public funds are increasingly being used to pay for them. The legislature further finds that the aforementioned decisions decriminalizing most abortions neither require nor authorize their performance at public expense. The legislature likewise finds that a substantial number of citizens have objections to nontherapeutic abortions for reasons of conscience or on ethical grounds. On the basis of the foregoing findings the legislature reaffirms the positive value of human life for the well-being of this state and its citizens, and also affirms that the encouragement and subsidy of nontherapeutic abortions by federal, state or local government bodies is not in the best interests of the people and does not serve the common good. It is therefore declared to be the public policy of this state that nontherapeutic abortions shall not be subsidized. The following statutory provisions shall be broadly construed to effect the objectives set forth in this section.

20.927 Subsidy of abortions prohibited. (1) Except as provided under subs. (2) and (3), no funds of this state or of any county, city, village or town or of any subdivision or agency of this state or of any county, city, village or town and no federal funds passing through the state treasury shall be authorized for or paid to a physician or surgeon or a hospital, clinic or other medical facility for the performance of an abortion.

THE OPTOMETRIST REFERRAL LAW

With the enactment of 1977 Assembly Bill 281, optometrists in Wisconsin are permitted to use some topical drugs. The law, Chapter 280, Laws of 1977, includes a **mandatory** referral section—the first of its kind in this state. It is reprinted below since some physicians undoubtedly will be receiving referrals in the near future.

449.19 Referral to other medical specialists. If, during the course of examining a person, an optometrist determines the possibility of the existence of a pathological condition, the optometrist shall so advise the person and shall refer the person to an appropriate medical specialist for further evaluation.

(2) (a) This section does not apply to the performance by a physician of an abortion which is directly and medically necessary to save the life of the woman or in a case of sexual assault or incest, provided that prior thereto the physician signs a certification which so states, and provided that, in the case of sexual assault or incest the crime has been reported to the law enforcement authorities. The certification shall be affixed to the claim form or invoice when submitted to any agency or fiscal intermediary of the state for payment, and shall specify and attest to the direct medical necessity of such abortion upon the best clinical judgment of the physician or attest to his or her belief that sexual assault or incest has occurred.

(b) This section does not apply to the performance by a physician of an abortion if, due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior thereto the physician signs a certification which so states. The certification shall be affixed to the claim form or invoice when submitted to any agency or fiscal intermediary of the state for payment, and shall specify and attest to the direct medical necessity of such abortion upon the best clinical judgment of the physician.

(3) This section does not apply to the authorization or payment of funds to a physician or surgeon or a hospital, clinic or medical facility for or in connection with the prescription of a drug or the insertion of a device to prevent the implantation of the fertilized ovum.

(4) In this section, "abortion" means the intentional destruction of the life of an unborn child, and "unborn child" means a human being from the time of conception until it is born alive.

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59.07 (136) SUBSIDY OF ABORTIONS RESTRICTED. No county or agency or subdivision of the county may authorize funds for or pay to a physician or surgeon or a hospital, clinic or other medical facility for the performance of an abortion except those permitted under and which are performed in accordance with s. 20.927.

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66.04 (1) (m) *Sudsidy of abortions restricted.* No city, village or town or agency or subdivision of a city, village or town may authorize funds for or pay to a physician or surgeon or a hospital, clinic or other medical facility for the performance of an abortion except those permitted under and which are performed in accordance with s. 20.927.

LABORATORY CERTIFICATION PROGRAM

The 1977 Budget Bill authorized the Department of Health and Social Services to charge a "user fee" for laboratories required to be certified by the State of Wisconsin. The actual Budget Bill language states:

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143.15 (4) of the statutes is amended to read:

143.15 (4) The department, after conducting an evaluation *and receiving a fee for each specialty area by the laboratory,* shall issue an appropriate certificate of approval to the laboratory, covering those examinations it has evaluated which have met the minimum standards established by the department. A certificate of approval shall be valid for 12 months from the date of issue but shall be revoked by the department if the minimum standards established by the department for certification are not met within 2 successive evaluations. ~~Such~~ *The* evaluations must occur within 60 days of the annual renewal of the certificate of approval.

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143.15 (7) of the statutes is repealed and recreated to read:

143.15 (7) The department shall promulgate rules establishing a fee schedule to offset the cost of the certification of laboratories and the collection of fees. The fees established for each specialty area shall be graduated to ~~reflect the volume of tests performed~~.

* * *

The Administrative Rules of the Department, over the strong objections of the Society, set certification fees according to the following schedule:

H 38.21 Fees. (1) DETERMINATION OF FEES. The fee for certification or recertification of a laboratory shall be determined by the number of testing specialties for which a laboratory offers services and requires certification, as follows:

(a) One specialty	$ 75
(b) Two specialties	$ 200
(c) Three specialties	$ 375
(d) Four specialties	$ 600
(e) Five specialties	$ 875
(f) Six specialties	$1,200

(2) ADDED SPECIALTIES. A fee of $250 shall be charged for each specialty added during the year.

(3) REFUNDS. Certification fees are not refundable.

(4) EXCEPTIONS. State hospitals and state institutions, and all official public health agency laboratories are exempt from certification fees.

(5) USE OF CERTIFICATION FEES. Certification fees shall be used to offset the cost of the certification of laboratories and the collection of fees.

* * *

The State Medical Society is currently developing a petition to be presented to the Legislative Joint Committee for the Review of Administrative Rules

in an attempt to have this fee schedule overturned and to have the entire certification program reviewed for effectiveness and need. That petition will be presented to the Committee sometime during the summer of 1978.

GOOD SAMARITAN LAW

Assembly Bill 96 created a new general Good Samaritan Law to replace one enacted by the 1975 Legislature. Signed into law on November 16, 1977, the new law reads as follows:

CHAPTER 164, Laws of 1977

448.03 (2) (i) and (4) of the statutes are amended to read:

448.03 (2) (i) Any person furnishing medical assistance or first aid at the scene of an emergency ~~as defined in sub. (4).~~

(4) (title) DEFINITION. ~~No person licensed or certified under this chapter, who in good faith renders emergency care at the scene of an emergency, is liable for any civil damages as a result of acts or omissions by such person in rendering the emergency care. For the purpose of~~ *In* this ~~subsection~~ *section,* "the scene of an emergency" means areas not within the confines of a hospital or other institution which has hospital facilities or the office of a person licensed or certified under this chapter.

895.48 of the statutes is created to read:

895.48 Civil liability exemption emergency care. Any person who renders emergency care at the scene of any emergency or accident in good faith shall be immune from civil liability for his or her acts or omissions in rendering such emergency care. This immunity does not extend when employes trained in health care or health care professionals render emergency care for compensation and within the scope of their usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of any emergency or accident, enroute to a hospital or other institution equipped with hospital facilities or at a physician's office.

EMERGENCY HOSPITAL SERVICES

The Legislature, in response to some constituent pressure, enacted into law 1977 Assembly Bill 624—Chapter 361, Laws of 1977. This law prohibits hospitals from delaying treatment to persons in emergency situations. The bill takes effect July 1, 1978:

146.301 Refusal or delay of emergency service.

(1) In this section "hospital providing emergency services" means a hospital which the department has identified as providing some category of emergency service.

(2) No hospital providing emergency services may refuse emergency treatment to any sick or injured person.

(3) No hospital providing emergency services may delay emergency treatment to a sick or injured person until credit checks, financial information forms or promissory notes have been initiated, completed or signed if, in the opinion of one of the following, who is an employe, agent or staff member of the hospital, the delay is likely to cause increased medical complications, permanent disability or death:

(a) A physician, registered nurse or emergency medical technician-advanced (paramedic).

(b) A trained practical nurse under the specific direction of a physician or registered nurse.

(c) A physician's assistant or any other person under the specific direction of a physician.

(3m) Hospitals shall establish written procedures to be followed by emergency services personnel in carrying out sub. (3).

(4) No hospital may be expected to provide emergency services beyond its capabilities as identified by the department.

(5) Each hospital providing emergency services shall create a plan for referrals of emergency patients when the hospital cannot provide treatment for such patients.

(6) The department shall identify the emergency services capabilities of all hospitals in this state and shall prepare a list of such services. The list shall be updated annually.

(7) A hospital which violates this section may be fined not more than $1,000 for each offense.

Effective date. This act shall take effect July 1, 1978.

CHANGES UPCOMING

In addition to the laws mentioned above, the Governor will be acting on one remaining piece of legislation during the next several weeks—changes in the Wisconsin Mental Health Act. 1977 Assembly Bill 898 is awaiting action by Governor Martin Schreiber. Details regarding this Act will appear in a future issue of the *Wisconsin Medical Journal.*

Finally, the Joint Committee for the Review of the Administrative Rules has directed the Department of Health and Social Services to modify the Medical Assistance "psychotherapy" rule (PW-MA 25). Details of these changes also will be the subject of a future *Wisconsin Medical Journal* article. ■

Physician and Hospital Records: Retention and Inspection

A. Retention of Records

It is agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have, during the last two decades, declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* on this subject in 1959, which was reprinted in full in the June 1975 BLUE BOOK issue of the *Wisconsin Medical Journal.* (74 *WMJ* 30)

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4), which was enacted as part of Chapter 301, Laws of Wisconsin, 1959. Subsection (4) in revised form has been renumbered 804.10 (4) Wisconsin Statutes, 1975, and became effective January 1, 1976. It is reprinted in the box on page 27 of this article.

It should be emphasized that parts of the *Interpretation* are no longer relevant because of intervening amendments to the 1959 statute. Its principal value was that it represented the joint thinking of the State Medical Society and the Wisconsin Hospital Association, acting through their respective governing bodies and officers. Where there is a difference between the wording of the *Interpretation* and this article, the article governs.

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related reports, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers,

within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.

C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) the time the minor reaches the age of 10.

D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 19. If such patient remains mentally ill after reaching age 18, his guardian must start suit within 8 years of the alleged negligence, or before the patient is 19, whichever date occurs later.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;

2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records and Reports

Both the old and revised subsections limited the right to inspect and copy medical or hospital records and reports to situations where *no litigation* is pending respecting the medical care and treatment covered by the authorization. Once litigation is begun, situations involving the inspection or copying of medical records and reports are governed by other statutes. The revised text of the subsection, renumbered as 804.10 (4), which took effect January 1, 1976, is set out in the box on page 27 of this article.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have

STATUTE

Former Section 269.57 (4) of the Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization was revised and renumbered as of January 1, 1976, to read:

> "804.10 (4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

NOTES: The principal differences between the old and new statutes are:

1. The earlier statute permitted the inspection and copy on the written authorization of a patient or his representative of "any medical or hospital reports, photographs, records, papers and writings concerning [his] care or treatment."

The revised subsection imposes narrower requirements limited to "medical or hospital records or reports."

2. Former Section 269.57 (4) provided that a custodian of medical or hospital records who refused to comply with an authorization submitted by or on behalf of a patient was liable to such patient "for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs."

Section 804.10 (4) provides that such custodian "shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover." This is a much more severe penalty.

the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identify of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the authenticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" which are issued by the County Court, Probate Branch.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy. The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision, in the case of a physician's office, by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10 (4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports". The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care or treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. The statute does *not* require a physician or hospital, to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

As a final observation, although legal title to medical records and reports is in the physician or hospital, depending on their location, the general legal opinion is that such records and reports are held in the custody of the physician or hospital for the benefit of the patient. It is on that basis that they are made limitedly available to him or to persons designated by him. ■

MALPRACTICE PENALTIES FOR THE UNLICENSED

Section 448.12 of the Wisconsin Statutes, quoted below, is concerned with legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.12 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the sick without having a license or a certificate of registration, shall be liable to the penalties and liabilities for malpractice; and ignorance shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

Physician Guidelines: Blood-Alcohol Testing 1978

Introduction

The 1977 revision of the Implied Consent Laws (Chapter 193, Laws of 1977) changes the circumstances under which physicians may be called upon to obtain blood specimens for determination of blood alcohol concentration. The State Medical Society supported the revision because the medical profession is concerned about the tragic human toll caused by motor vehicle accidents and the major contribution to this by the alcohol impaired driver.

The following guidelines are offered in an effort to encourage physician participation in the identification of those drivers who abuse their driving privileges by operation of a vehicle when impaired by alcohol.

Summary of the Law

The theory of Wisconsin's Implied Consent Law is that every person (including minors) operating a motor vehicle on the state's roads is presumed to have consented to chemical "tests of his or her breath, blood or urine for the purpose of determining the presence or quantity in his or her blood of alcohol or controlled substances. Any such test shall be administered upon the request of a law enforcement officer."

In addition to the test administered at the request of the enforcement officer the person arrested may request the alternative test provided by the agency (this may be a blood test) or at his or her own expense have any qualified person of his or her own choosing administer a chemical test for such determination.

Blood may be drawn for such determination only by a physician, registered nurse, medical technologist, physician's assistant or person acting under the direction of a physician.

No person withdrawing blood for such purposes from the person arrested at the request of an enforcement officer, nor the employer or hospital where the blood is withdrawn, may incur any civil or criminal liability for the act except for possible civil liability for negligence in the performance of the act.

Recommended Guidelines

1. *Obtain request and consent in writing.* If possible, the physician should obtain both the request of the law enforcement officer to draw blood and the driver's consent in writing. Where it is not possible to obtain one or the other, such as the situation in which the driver is unconscious, a special notation should be made to explain the absence of the signature.

2. *Do not withdraw blood if the driver refuses.* The law provides for penalties if a person refuses the request of an enforcement officer to submit to a chemical test. The law does not define or limit what refusal may be and it is recommended that the physician not proceed if the person indicates refusal of the test in any way; this may take the form of specific verbal negation of consent or acts which demonstrate a refusal to consent or make the act potentially dangerous.

3. A person who is unconscious or otherwise not capable of withdrawing consent is presumed not to have withdrawn consent. Obtaining the specimen does not necessarily mean that the results will be admissible in court but that is not a medical decision and would have no bearing on whether or not the physician should follow the request of the police officer.

4. *Procedures.* Since requests for blood testing may come at unusual or inconvenient times, it is recommended that procedures be established in advance to meet these requests.

The person withdrawing the blood specimen must follow medico-legally acceptable procedures in obtaining the specimen, sealing the specimen, identification of the specimen, and in assuring an acceptable transmission of the specimen to a laboratory certified by the Department of Health and Social Services. The State Laboratory of Hygiene furnishes blood specimen containers, and instructions for their proper use, which simplify the assurance of medico-legal acceptability of the test.

5. *The physician remains liable for negligence.* While there is a general immunity from liability for physicians drawing blood under the Implied Consent Law at the request of a traffic officer, *when the person is under arrest,* this immunity does not relieve them from responsibility for negligence in the performance of their professional acts. Negligence in this regard would include a determination whether the place in which the sample is to be drawn and the equipment used meet acceptable hygienic standards. If they do not, it is recommended that the physician not take the sample until proper hygienic conditions are met.

6. *Police orders for blood test despite refusal.* Some law enforcement agencies may demand that a physician withdraw blood for blood-alcohol testing despite the person's refusal or for crimes other than those covered by the Implied Consent Law. Any such demand falls outside the professional liability protection of the Implied Consent Law and physicians who comply with these demands do so at their legal peril.

7. *Working arrangements with law enforcement officers.* The enforcement agency should assume the initiative for establishing working arrangements with

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Prepared by the Committee on Safe Transportation and adopted by the SMS House of Delegates, April 1978.

Copies of the form: REQUEST/CONSENT FOR DRAWING BLOOD, are available at a cost of 25¢ each upon request to: CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

physicians and hospitals for making the withdrawal of blood for chemical testing available; however, medical societies, hospital staffs or individual physicians may initiate the planning for the provision of this service. Proper topics for discussion and agreement in anticipation of the need include:

A. *Fee arrangements*
   1. Which agency will pay—certainly it is not up to the physician to attempt to obtain payment from the accused except where the test is done as the second alternative noted above under *Summary of the Law.*
   2. Establish the fee or fees for such service.
   3. Establish the fees for court appearance should that be required for prosecution of the case.

B. Responsibility for legal defense if charges are brought against the physician or his agent—there is no assurance against frivolous suits or protection if the officer should err in his arrest.

C. Procedures to be followed should the person refuse the test.

D. Responsibility for delivering the specimen to the laboratory, including provision for receipt from person taking possession of the specimen.

8. *Physician refusal.* Some physicians refuse to honor law enforcement and/or patient requests to withdraw blood for blood-alcohol testing. The question has been raised whether a law enforcement officer can require a physician to perform a professional service such as withdrawing blood. This issue is in dispute; the Attorney General has written: "Law enforcement officers have the power to require citizens to assist them where necessary. This power is referred to as the *posse comitatus.* Whether such power extends to and permits an officer to command a physician or other hospital technician to withdraw a blood sample is not at all clear. While a doctor or a lawyer, like any other citizen, could be ordered to assist an officer in making an arrest, it is not clear that such power extends to a demand for professional services from such a person."[1]

9. *Physician-patient relationship.* "If the police took a person to a hospital specifically for the purpose of having his blood tested for alcohol, no physician-patient relation would result." For confidentiality (of the results of the test) to present a problem, there must be a sufficiently well defined physician-patient relation to which confidentiality can attach.[2]

Conclusion

"The physician should not be reluctant to help the police secure objective evidence. It should be kept in mind that such evidence may help the accused just as it may hurt him. In any event the cause of justice is well served by the performance of this impartial function by the physician."[2]

References

1. Warren RW; Wisconsin Attorney General letter OAG 49-73, dated August 10, 1973.
2. Chayet NB; The Police, The Supreme Court and The Physician; *New England Journal of Medicine,* September 8, 1966, pp 548-549.

REQUEST/CONSENT FOR DRAWING BLOOD

The undersigned, _____, a law enforcement officer of the State of Wisconsin, hereby requests _____, M.D., to draw blood, pursuant to Section 343.305, Wisconsin Statutes, from_____, whom the undersigned arrested at _____, ___M., this date, for alleged criminal acts involved in driving a motor vehicle while under the influence of an intoxicant. The blood drawn will be used to perform a clinical test to determine the blood-alcohol level of the accused, which may be used as evidence against him.

Dated _____, at _____, ____M.
In the Presence of:

_____
_____
_____

_____
Name

_____
Title

The undersigned, _____, hereby consents to the drawing of blood from him by or under the direction of _____, M.D., pursuant to Section 343.305, Wisconsin Statutes. The undersigned understands that the blood is being drawn for the purpose of determining its alcoholic content and that the results of this determination may be used in connection with his prosecution on criminal charges involving driving while under the influence of an intoxicant.

Dated _____, at _____, ____M.
In the Presence of:

_____
_____

_____
Name

If unable to obtain signatures on either the request or consent, above, please explain below: _____

_____
_____
_____
_____

_____
Name

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MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes, to the Department of Health and Social Services.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of the June 1974 Blue Book issue.

17. Drug addiction?

No.

18. Abused or neglected children?

Yes. In addition to the situations covered in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL (page 25), the law now requires reports of 'neglected' children, those not receiving food, clothing, shelter or care (including medical care) so as to "seriously endanger" the child's health. Wilfull failure to report subjects a physician to a penalty; good faith reports provide immunity.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

Physicians: A helpful management tool in the conduct of your professional practice—

INSURANCE CHECKLIST

THE FOLLOWING INSURANCE CHECKLIST has been developed by the State Medical Society's Committee on Economic Medicine, with the assistance of Society consultants. It is provided as a benefit of membership and with the intent that it might be helpful to you in analyzing your various professional practice exposures and the extent to which substantial risks are covered by your insurance coverages.

The Committee wishes to emphasize that the checklist may not identify all of the potential risks pertaining to your particular practice needs. For this reason it is perhaps essential for you to confer extensively with your insurance agent/consultant to make it serve your professional practice needs in the most meaningful manner.

You will note there is no reference to professional liability insurance and this is due to the fact that almost all phases of this particular exposure have been provided for through mandated coverage pursuant to legislation.

Risk management and insurance coverage as it pertains to your professional endeavors are subject to change just as these factors pertain to your general personal and family affairs. Therefore, it is recommended that you consider this a matter which should be studied and acted upon as needed on a periodic basis.

The Committee on Economic Medicine hopes you will find this a helpful management tool in the conduct of your professional practice.

DANIEL K SCHMIDT, MD, *Chairman*
Committee on Economic Medicine

* * *

A. Property—Building—Contents

1. What perils are insured against?
   - ☐ Fire, Extended Coverage & Vandalism, Sprinkler Leakage
   - ☐ All Risk Including Burglary & Theft

   Is coverage on a:
   - ☐ Replacement Cost Basis-No Deduction for Depreciation?
   - ☐ Actual Cash Value Subject to Depreciation?
2. Is coverage limit adequate to comply with coinsurance clause? ☐ Yes ☐ No
   Does contents coverage include coverage for building items installed at your expense and in which you have an Insurable Interest until lease expires? ☐ Yes ☐ No
   If building coverage is provided, is there any exposure to loss due to condemnation after a fire loss due to nonconforming construction—If so is policy properly endorsed? ☐ Yes ☐ No
3. Review exposure and policy coverage for outdoor signs and awnings. ☐ Yes ☐ No

B. Time Element

1. Is Business Interruption or loss of earnings coverage required and carried? ☐ Yes ☐ No
2. Same as A1 above
3. Same as A2 above
4. If building is owned, is rental value coverage required and carried? ☐ Yes ☐ No
   Is limit adequate to comply with coinsurance clause if any and maximum anticipated loss period? ☐ Yes ☐ No
5. Is extra expense coverage required and carried? ☐ Yes ☐ No

C. Inland Marine

1. Is glass coverage required and carried? ☐ Yes ☐ No
2. Is Accounts Receivable Records Coverage required and carried? ☐ Yes ☐ No
   In absence of coverage are records properly protected in a fire resistant safe or cabinet and/or are records duplicated and kept off premises? ☐ Yes ☐ No
3. Is there any requirement for "Fine Arts" coverage? ☐ Yes ☐ No
4. Is there any requirement for "Valuable Papers & Records Coverage" to cover cost of research and development necessary to reproduce records destroyed? ☐ Yes ☐ No
5. Is data processing coverage needed? ☐ Yes ☐ No
6. Do lease requirements of leased personal property require All Risk - floater insurance? ☐ Yes ☐ No
7. Other Inland Marine Coverages:
   Insurance Floater
   Camera Floater
   Portable Equipment

D. General Liability (Excluding Professional)

1. Is coverage on a comprehensive form? ☐ Yes ☐ No
2. Is coverage included for Personal Injury including suits involving employment? ☐ Yes ☐ No
   Is coverage provided without participating in loss? ☐ Yes ☐ No

3. Is coverage provided for liability assumed under contract? ☐ Yes ☐ No

4. Is coverage provided for fire legal liability for leased premises? ☐ Yes ☐ No
It is preferable for the premises lease to be amended to provide Waiver of Subrogation in lieu of the above.

5. Are special extensions or coverages required for Watercraft - Owned/Nonowned/aircraft - Owned/Nonowned? ☐ Yes ☐ No

6. Host Liquor (not sale) liability coverage ☐ Yes ☐ No

7. Additional Insured Employees ☐ Yes ☐ No

8. Products ☐ Yes ☐ No

9. Independent Contractors ☐ Yes ☐ No

E. Auto Liability and Physical Damage

1. Are all owned autos insured for: ☐ Yes ☐ No
   Liability - Bodily Injury and Property Damage?
   Medical Payments?
   Uninsured Motorists?
   Collision?
   Comprehensive?

   Is special coverage required for installed radio receiving/transmitting equipment? ☐ Yes ☐ No

2. Is coverage provided for **your** liability for employees vehicles used in your behalf or hired vehicles thru a Non-Owned & Hired Auto endorsement? ☐ Yes ☐ No

3. Fellow employee coverage ☐ Yes ☐ No

F. Excess Umbrella Liability (Excluding Professional)

1. Is coverage carried? ☐ Yes ☐ No

2. Is limit adequate? ☐ Yes ☐ No

3. Do underlying policy (items D & E) limits meet Umbrella requirements? ☐ Yes ☐ No

4. Is coverage provided on a First Dollar Defense basis for those suits not covered by underlying policy? ☐ Yes ☐ No

5. Any special exclusions which require further explanation? ☐ Yes ☐ No

G. Crime

1. Is employee dishonesty coverage carried with adequate limit? ☐ Yes ☐ No

2. Is employee dishonesty coverage carried as required by ERISA - 1974? ☐ Yes ☐ No

3. Is coverage required for other crime areas? ☐ Yes ☐ No
   Money & Securities On & Off Premises? ☐ Yes ☐ No
   Depositor's Forgery ☐ Yes ☐ No
   Credit Card Forgery? ☐ Yes ☐ No
   Contents Burglary & Theft if not provided under Item A ☐ Yes ☐ No

H. Worker's Compensation

1. Is coverage required and carried? ☐ Yes ☐ No

2. Are certificates of insurance requested from all "independent contractors" performing work in your behalf to prevent additional premium charges? ☐ Yes ☐ No

3. Any loss frequency or severity which indicates problems and are you receiving company engineering assistance? ☐ Yes ☐ No

4. Does policy cover employee injury in states other than Wisconsin? ☐ Yes ☐ No

5. Voluntary Compensation exposure ☐ Yes ☐ No
   Sponsored athletic groups exposure ☐ Yes ☐ No

I. Boiler Coverage

1. Is coverage required for explosion of steam or hot water boiler? ☐ Yes ☐ No

2. Is coverage on a replacement cost basis - no deduction for depreciation? ☐ Yes ☐ No

3. Is limit adequate? ☐ Yes ☐ No

4. Is coverage provided for other boiler exposure areas such as:
   Business Interruption or Loss of Earnings? ☐ Yes ☐ No
   Rental Value? ☐ Yes ☐ No
   Extra Expense? ☐ Yes ☐ No

5. Is coverage required for other "machinery" exposures, particularly if you are the owner of a building, such as but not limited to:
   Air conditioning equipment? ☐ Yes ☐ No
   Electrical switchboards? ☐ Yes ☐ No
   Transformers? ☐ Yes ☐ No
   Unfired Pressure Vessels? ☐ Yes ☐ No
   Electric Motors? ☐ Yes ☐ No
   Compressors? ☐ Yes ☐ No

J. Miscellaneous - Have exposures been examined for the following areas of coverage:

1. Fiduciary Responsibility Insurance? ☐ Yes ☐ No

2. Directors & Officers Liability - for own corporation & Boards on which you may serve ☐ Yes ☐ No

K. Make sure the agent reviews ISO (Fire Rating Bureau) inspection reports for rate surcharges due to correctable property conditions. ■

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GENERAL ELECTRIC

Problems of a Physician's Widow

Following the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

> "The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Ave, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patient will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow should consult her attorney as to whether

the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney. ■

Adoption

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. ■

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Chapter 246, Laws of 1977, requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

REFER CHILD ADOPTION CASES TO THESE LICENSED AND PUBLIC AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc. 6800 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson Street, Milwaukee 53202.

Catholic Social Services, 207 East Michigan Street, Milwaukee 53202.

Catholic Charities, Inc., 128 South Sixth Street, Box 266, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Catholic Social Services, 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Seven Sorrows of Our Sorrowful Mother Infants' Home Necedah 54646.

World Family Ltd, 4906 West Fond du Lac Ave, Milwaukee 53216

The Human Element, Inc, 2701 N 56th St, Milwaukee 53201

PUBLIC AGENCIES:

*Division of Economic Assistance (See page ?? for list of Regional Offices).

*Milwaukee County Department of Social Services, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

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* Nondenominational.

MATERNITY HOMES

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19305 West North Ave., Brookfield 53005.

St Francis Maternity Residence, 709 S Tenth St, La Crosse, 54601.

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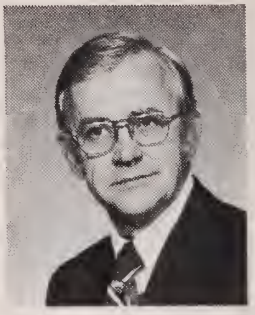

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You are being sued for malpractice, or

What the physician should know about malpractice litigation

THIS BRIEF OUTLINE of the medical malpractice process has been prepared to enlighten physicians about what could be an emotional and trying experience—a medical malpractice suit. The State Medical Society's Medical Defense Committee is interested in physicians of this state having the best possible perspective on this process. This memorandum is meant to answer the common questions that arise once a suit occurs. Attorneys Maria Lubitz and Richard Cates collaborated in the formation of this paper.

The Medical Defense Committee welcomes your comments on this paper. It is hoped that physicians will not need to review this text again. Prevention is, of course, our best medicine.

RUSSELL A QUIRK, MD
Chairman
Medical Defense Committee
State Medical Society of Wisconsin

In response to current medical malpractice problems, the Medical Defense Committee has prepared the following reference information concerning (1) the nature of a malpractice claim and its resolution under the current law of the State of Wisconsin; (2) the role of the defense attorney; and (3) the responsibilities of a physician with respect to the litigation of a malpractice claim.

It is suggested that you file this information with your malpractice insurance policy.

NATURE OF A MEDICAL MALPRACTICE CLAIM

Claims of medical malpractice are based on bodily injury or the death of a patient allegedly resulting from professional services rendered by a physician. Generally, a malpractice claim will be grounded on the legal theory which permits recovery for injuries from someone who has been negligent.

Negligence is defined as the failure to exercise ordinary care in light of a foreseeable risk. In the case of medical malpractice based on negligence, it is essential that the allegation be made that the care exercised failed to conform to the generally accepted standards for the practice of medicine in the particular medical area involved in the case. In other words, the claimant must assert that the doctor failed to exercise the care which physicians performing the same sort of medical service ordinarily would have exercised.

Claims of malpractice based on negligence may involve the application of the doctrine of *res ipsa loquitur*. This doctrine applies where the instrumentality inflicting the injury was under the exclusive control of the defendant, and the injury in question would not ordinarily occur in the absence of negligence. Under these circumstances negligence may be inferred, obviating proof by an expert medical witness. The defendant must then prove that the injury did not, in fact, result from the failure to exercise due care.

Occasionally claims against physicians arising out of the rendering of professional services may be based on breach of contract, that is, the failure to bring about a promised result; vicarious liability for the acts of the physician's agents or employees; abandonment; false imprisonment; and breach of confidence.

A. Litigation of a malpractice claim

The Statute of limitations for commencing a suit for malpractice is three years.

In the case of a minor, the suit must be filed by the child's tenth birthday, or the adult statute of three years, whichever is later. (Assembly Bill 705, Chapter 390, Laws of 1977, effective May 24, 1978)

B. Proceedings before Patients Compensation Panels

The recently enacted Patients Compensation Panels law applies to all acts of medical malpractice occurring after July 23, 1975. This law requires that the patient must submit his claim of malpractice to a screening panel before commencing a court suit. The procedure is instituted by the filing of a Submission of Controversy with the State Court Administrator.

The Submission of Controversy sets forth the name of the Petitioner (the patient or his representative), the name of the Respondent (the physician, osteopath, hospital), the date of the treatment giving rise to the claim, the condition which the treatment was rendered, a short statement of the injury, and whether the amount of the claimed recovery is $10,000 or under, or whether it exceeds $10,000.

The State Court Administrator must serve notice of the filing of the Submission of Controversy on all named respondents by first class mail, and he must assign the controversy to the appropriate compensation panel.

In claims of $10,000 or less, the controversy shall be heard by an informal panel unless both parties stipulate in writing that the hearing be by a formal panel. The informal panel is composed of three members: one physician; one attorney; and one public member.

In claims over $10,000, the controversy shall be heard by an informal panel unless one party requests in writing that it shall be heard by a formal panel. The formal panel is composed of five members; one physician; one physician of the specialty of the respondent or a representative of the same field of health care as the respondent; one attorney; and two public members.

The statutes provide for the following time schedule in proceedings before compensation panels: hearing on the claim must be scheduled within 60 days of the filing of the Submission. The hearing must be held within 120 days of the filing of the Submission. All medical reports and other documentary evidence must be filed with the panel two weeks prior to the date of the hearing. The panel must render its decision within 30 days of the hearing. Any party dissatisfied with the decision of the panel must commence an action in courts within 120 days of the date of the decision.

The discovery process whereby the petitioner and the respondent explore the case of the opposing party takes place in the period between receipt of the notice of the Submission of the Controversy and the filing of the written reports with the panel. This process is essentially similar to that undertaken in court proceedings and will be discussed more fully under the topic.

C. Court actions

A court action is commenced by the filing of a Summons and Complaint with the court. Conformed copies of the Summons and Complaint are served on each defendant, ordinarily by the sheriff of the appropriate county. Service, however, may be made by any person not a party to the lawsuit, and may be made on a member of the defendant's family or on his agent.

The Summons advises the defendant that he must answer the complaint or otherwise respond thereto within 20 days. There is a liberal policy of granting short extensions of time for the filing of the answer. Failure to answer or otherwise respond to the complaint may result in the entry of a judgment or default against the defendant.

The Complaint sets for the plaintiff's cause of action, usually in the form of a recitation of the ultimate facts in support of the legal theory underlying the claimed recovery.

In view of the brief time available to the attorney for the defendant for investigation of the allegations of the complaint, the answer generally will be couched in terms of a general denial. The pleading stage of a lawsuit generally is perfunctory in nature, but it serves to set in motion the discovery process to explore the cases of the respective parties which furnishes the requisite information to enable the attorneys to evaluate the merits of the claim and of the defense necessary to assess the possibility of dismissal of the claim or of settlement of the case, and finally to prepare for trial.

Although a lawsuit is adversary in nature, the law permits and favors full and fair disclosure of the cases of the respective parties. To that end each party, by its attorney, may compel the opposing party and any of its witnesses to respond to questioning in the form of written interrogatories requiring sworn answers and depositions under oath before a court commissioner. The person who is being questioned is represented by the attorney of the party whose witness he is. A number of claimant's attorneys employ trained investigators to assist them in their preparation of their cases.

The discovery process may vary in time from about six months in some state courts to a year or more in federal court and the more congested courts of Milwaukee County. After completion of this process, the judge to whom the case has been assigned orders the parties and counsel to appear at a pretrial hearing to determine the status of the case.

At this time, the parties may commence serious settlement discussions which are evaluated in light of the respective attorneys' experience and judgment concerning the potential of their cases on trial.

Judges vary in how active they are toward securing settlement. Some favor settlement to save court time and the expense of jurors and witnesses. The attitude of the particular judge is a factor to be considered by the attorneys in planning strategy at the pretrial hearing and in considering the possibility of settlement.

If the case is not settled, it will usually be scheduled for trial at the time of the pretrial hearing, usually for the earliest free time of the court which may vary from a month to more than a year depending on the case load of the court.

A malpractice case normally will be tried before a jury. After selection of the members of the jury, the course of the trial includes the opening arguments of counsel; the presentation of the plaintiff's case; the presentation of the defendant's case; the instruction of the jury and closing arguments of counsel.

The presentation of the cases of the respective parties is by direct examination of the witnesses offered by each party with cross examination of each witness by the attorney for the opposing party and then redirect examination by counsel for the party offering the witness, as well as by the offer of documentary and physical evidence such as hospital records, x-ray films, demonstrative models, charts, medical texts, etc.

In a medical malpractice case based on negligence in the treatment of the patient, the plaintiff usually must support his contentions by the testimony of an expert medical witness. Similarly, the defense will offer expert testimony to support its contentions. Unlike the ordinary witness whose testimony is restricted to facts within his knowledge, the expert witness may state his opinion usually in answer to a hypothetical question.

An appeal from the judgment must be taken: 1) 180 days (6 months) from the date the clerk of courts files the judgment; or 2) the 180 days is reduced to 90 days (3 months) if written notice of the date the clerk filed the judgment is served upon the losing party.

THE ROLE OF THE DEFENSE ATTORNEY

The responsibility for the conduct of the litigation and the presentation of the defense rests with the attorney who represents the physician at the instigation of the insurance carrier.

The attorney should inform the physician of the mechanics of the litigation process and the strategy to be used in providing a defense. The significance of direct and cross examination and of the various objections that may be raised by either party in the proceedings, as well as other technicalities of the proceedings should be explained by the defense attorney. In general, the defense attorney must undertake the educational process of preparing his client for the process of litigating a medical malpractice claim against the physician.

Decisions on whether the case shall be settled and whether an appeal shall be taken from an adverse judgment are ultimately reserved to the insurance carrier.

RESPONSIBILITIES OF THE PHYSICIAN WITH RESPECT TO MALPRACTICE LITIGATION

It is essential that the physician has read and understands the terms of his policy of malpractice insurance. Any questions he may have concerning the terms of coverage can be discussed with his agent or by inquiry to the Insurance Company.

The physician must promptly notify the insurance carrier if he has knowledge or should have knowledge that a patient may assert a claim against him. Similarly, he must promptly notify the insurance carrier if he receives first class mail notice from the State Court Administrator that a Submission of Controversy has been filed naming him as a respondent or of the service of a Summons and Complaint on him. After the physician has appropriately advised the agent, the latter will inform the carrier, who will forward the respective pleadings to the attorney who will proceed with the case. At this time, the insurance carrier also will begin its investigation of the case.

The physician should then review the circumstances on which the patient's claim is based; he should acquaint himself specifically with the area of medicine involved; and he should contact the attorney handling the case and seek an appointment for an appropriate time, that is when the attorney's schedule has permitted him time to give the case his personal attention.

The physician can materially aid the defense attorney in the preparation and presentation of the defense by being informed of the medical aspects of the controversy. Most importantly, he should be advised of the appropriate demeanor in the proceedings which requires a degree of certainty concerning the subject matter of his testimony and of emotional control to convey the impression to the trier of fact, be it panel, judge or jury, that he is a believable fair-minded person.

If the defense attorney does not on his own provide the necessary technical and strategic information described above regarding the tort process, the physician should initiate the process by setting up a conference with the attorney.

Although the decision to settle or take an appeal rests with the insurance carrier, the physician is entitled to, and should insist on being furnished with the rationale of the carrier's decision. ■

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The Regional Office of the DEA in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P O Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

MEDICOLEGAL FIRST AID

THE CONTINUING AND RAPID scientific advances coupled with the increased demands and expectations of patients frequently results in an imbalance between the art and science of medicine. A proper blending of the art and science by the practicing physician and his associates contributes much in the way of patient and professional satisfaction. Throughout the land professional liability insurance carriers are announcing substantial premium increases; some are limiting their coverage to lesser risk classifications; and others are withdrawing entirely from writing this category of protection. From all the Council's Committee on Economic Medicine can ascertain, the professional liability insurance market is less restricted in Wisconsin than it is in several other jurisdictions. Even so, SMS members are required to pay substantial premium rates for this protection which is so essential to the practice of medicine. The Committee on Economic Medicine continues its efforts to keep abreast of developments in this important area and offers the following points to physicians.

I. Keep your expired professional liability policies

Comment: The standard three-year Statute of Limitation is not applicable to minors or incompetents. You may be sued many years after the alleged event. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

II. Keep good records and retain them for years

Comment: See Comment to No. I. In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

III. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent"

Comment: The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

IV. The "Locality Rule" has been abolished in Wisconsin

Comment: The practitioner be he "generalist" or "specialist" is now subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

V. Continued membership in your Society is recognized by the Courts as vital for continuing education

Comment: The Courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cites the AMA JOURNAL as authority. The same reasoning applies to SMS JOURNAL and the Society's continuing education programs.

VI. Refrain from ill-advised remarks; THINK BEFORE YOU SPEAK

Comment: Many of the malpractice cases have their genesis in the unfortunate thoughtless spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

VII. Give prompt notice to insurer in the event of an "incident"

Comment: Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

VIII. Provide Continuity of Care

Comment: Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up and; in either event this should be documented in the patient's record.

IX. Be alert to the suit-prone "litigious" patient

Comment: Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, extreme caution should be exercised so as to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

X. Avoid discussion of your liability insurance

Comment: The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

XI. Always exercise discretion in the collection of accounts

Comment: Turning a delinquent account over to a collection agency — especially if there is any evidence of patient dissatisfaction may well be the basis for a counter charge in the form of a suit against the physician. While the physician is entitled to remuneration for professional services rendered, foregoing payment may be less of a loss than being a defendant in a lawsuit.

XII. Avoid direct contact with a plaintiff's attorney

Comment: In the event of a claim or suit and the plaintiff's attorney attempts to contact you, you are well advised to refer him to your own attorney. Any communication you may have with a plaintiff's attorney — no matter how well intentioned — might very well compromise your defense if the case proceeds to litigation.

The Committee on Economic Medicine will continue to monitor current literature relating to medical professional liability claims to ascertain additional factors which may give rise to suits against physicians. As they are identified, they will be communicated to you through the MEDIGRAM and in other ways. In the interim physicians are encouraged to communicate any helpful hints to the committee so they may be shared with your colleagues in furtherance of both the public and professional interest. ■

A basic overview of EDS Federal's computerized claim processing system

I. INTRODUCTION

To promote improved understanding of computerized health claims processing, this article will present some basic operational definitions and trace the steps that a claim goes through during routine systems processing.

The claim processing system described below is used by E.D.S. Federal Corporation (Electronic Data Systems). As the claims processing agent for the Wisconsin Medicaid Program, E.D.S.F. processes in excess of 400,000 claims per month, including some 120,000 claims for physicians' services.

II. SOME BASIC TERMS DEFINED

The following are definitions of some common terms pertaining to routine claims processing.

1. *ICN (Internal Control Number)*—a unique claim number assigned to each claim for identification purposes. (Stamped onto claim upon receipt.)
2. *CRT (Cathode Ray Tube)*—a computer terminal used for entry of claim information into the processing system and for looking up information pertinent to claims processing (e.g., claim status).
3. *RETURN CLAIM*—a claim that is returned to the submitting physician with a RETURN LETTER explaining what additional information is needed to process the claim. (Note: A RETURN CLAIM is no longer pending in the system and the claim must be resubmitted with any corrections in order for processing to resume.)
4. *EDITS*—routine information checks (performed automatically by the processing system) which test the clerical validity of the claim information.
5. *AUDITS*—routine information checks (performed automatically by the processing system) which compare claim information against previous payments and Medicaid Program payment guidelines.
6. *WORKSHEET*—a physical report which is an exact facsimile of the original claim. Used by Resolutions clerks when a claim has "failed" an edit or audit and needs to be checked for correction or denial.
7. *PENDING CLAIM*—a claim that is still going through the computer processing sequence (i.e., still in the edit and audit sequence or in the financial end) and has not yet appeared as paid or denied on a Remittance Advice. (Note: A RETURN CLAIM has been taken out of the system and is *not* a pending claim.)
8. *CHECKWRITE*—weekly payment run during which Remittance Advices and checks are printed for all providers who have had claims paid or denied in the preceding week.
9. *R.A. (Remittance Advice)*—a weekly statement summarizing claims payments, denials, and any adjustments or financial transactions for the preceding week. (Also called a Remittance and Status Report.)
10. *EOB CODES (Explanation of Benefits Codes)*—numeric codes explaining claim disposition (a narrative explanation of the codes appears at the end of the R.A.). If claim is denied or paid at less than the billed amount, the reason will be given by the EOB Code.
11. *FINALIZED CLAIM*—a claim that has been paid or denied and is no longer pending within the computer processing system.
12. *PROVIDER*—a health care professional, institution, or medical supplier enrolled in the Medicaid Program (i.e., assigned an active, nine digit provider number enabling the individual or institution to file for reimbursement of supplies or services provided to eligible Medicaid recipients).

III. STEPS IN CLAIM PROCESSING

The following account describes the main events of claim processing, starting with claim receipt and ending with claim disposition on the Remittance Advice.

Claim receipt—ICN assignment/microfilming

As claims are received, a unique document number called an ICN (Internal Control Number) is assigned to each one for identification purposes. The claims are then microfilmed for future access and sent to an examiner in the claims area.

Claim review/entry into system

A claim examiner reviews the claim to determine if all the necessary claim fields (*eg*, health care provider name and address, identifying provider name, etc) are completed.

If the claim is not complete, the claim will be returned to the provider with a return letter requesting whatever information is missing.

If all necessary claim information is intact, the claim is entered into the computerized processing system via a CRT (Cathode Ray Tube). This device is an online computer terminal consisting of a keyboard and a TV-like screen. The entering clerk types the claim information onto the TV screen, reviews the entry, and then enters the claim into the system (thus "activating" the claim).

Once the claim enters "the system", it is automatically subjected to a series of information checks called EDITS and AUDITS.

Edit cycle—in system

EDITS check each piece of information given on the claim against master file information and against

Prepared by Ms Dale K Mitchell of EDS Federal. Physicians' office staffs having claims processing problems may contact the Correspondence Unit at EDS Federal: toll-free 1-800-362-9111.

basic claim requirements. For example, one edit would confirm that the pharmacy name and identifying provider number "match" (*ie,* that the provider is using his/her correct assigned nine digit provider number). Another edit would check to make sure that the patient's "recipient" number is correct. Over 200 such edits are involved in the routine processing of an average claim.

If any piece of information on the claim "fails" an edit condition (*ie,* the provider number is incorrect, the recipient number is incorrect, etc), a "worksheet" is generated, thus temporarily holding up or "suspending" the claim. A Resolutions Clerk then examines the problem amd makes a correction to enable the claim to resume processing. The claim must be reexamined for each edit "failed." In some instances, edit "failure" may cause claim denial (*e.g,* when the provider or recipient cannot be identified on the EDSF file as eligible to participate in the Medicaid Program, etc.)

When a claim passes successfully through the edit cycle (or "fails" but is corrected and subsequently resumes processing), it is then subjected to a series of AUDIT checks.

Audit cycle—in system

AUDITS check claim information against previously processed claims and against coverage guidelines. All Wisconsin Medicaid Program guidelines are established via directive of the responsible State Agency, the State Bureau of Health Care Financing. Audits monitor such things as whether the services have been previously billed (*i.e.,* is this a "duplicate" claim), whether in fact the service is a covered benefit (*e.g,* is assistant surgery payable for this procedure), or whether the service frequently is covered (*e.g,* is this a "once in a lifetime" procedure). Failure of an audit may mean automatic denial of a claim.

Claims that "fail" audits also generate worksheets and require Resolution Clerk review. As mentioned above, failure of some audits (*e.g,* when the claim is a duplicate of a previously paid item; when the service is not a covered benefit, etc) will mean automatic denial of the claim.

A claim that successfully completes the audit cycle will proceed to FINANCIAL (*ie,* it is released to PAYMENT CYCLE). Claims released from the audit cycle to the payment cycle are also referred to as "Released to Financial."

Financial end—in system

Claims released for financial disposition are held until the weekly CHECKWRITE and RA printing. Each Friday night the claims are released from the financial cycle and preparation of Remittance Advices and checks begins.

Finalized claims are listed on the RA in alphabetical order according to patient's last name. An EOB Code will appear with each item to explain any payment reduction or payment exception such as recipient ineligibility.

Claim payments are made in accordance with Medicaid Program directive. The billed amount and the allowable amount appear in separate columns on the Remittance Advice; payment is based upon applicable Medicaid reimbursement criteria for the particular services or supplies billed.

Denied claims are identified by a rejection reason which appears as an EOB Code in the far right column of the RA (The narrative explanation of the EOB Code prints out at the end of the RA). In some cases (*eg,* recipient number was incorrectly recorded) the claim may be corrected and resubmitted.

When payment has been made but is incorrect (*eg,* wrong service quantity or wrong service code caused improper payment), an adjustment must be requested to correct payment. (EDSF has special forms for this use).

IV. CONCLUSION

Hopefully, this simplified account has given those of you with Wisconsin Medicaid involvement some insight into what happens to claims during the course of computerized claim processing. It should also be noted at this time that in addition to the routine "paper claim" mode of processing described above, EDS Federal processes a number of "tape-to-tape" billings submitted by health care providers with special billing arrangements. ■

EDITOR'S NOTE: The State Medical Society's Physicians Alliance stands ready to assist physicians' office staffs with EDSF claims problems. Call Marge May toll-free at SMS headquarters: 1-800-362-9080.

SMS POSITION ON PHYSICIAN ADVERTISING

The State Medical Society of Wisconsin's official position on physician advertising, as adopted by the Council April 12, 1978, is as follows: "The State Medical Society of Wisconsin does not have a policy prohibiting advertising by physicians excepting that such advertising may not contain information misleading or deceptive. The American Medical Association has issued guidelines on "Advertising and Solicitation" which might be useful in helping physicians determine the appropriateness of advertising plans. These guidelines are not to be interpreted as rules or regulations of the State Medical Society of Wisconsin, but are for informational and guidance purposes only." See adjacent page for the AMA guidelines.

AMA Judicial Council Statement on Advertising and Solicitation

THIS STATEMENT reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians. The Principles of Medical Ethics are intended to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

Advertising.—The Principles do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media for advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the Principles of Medical Ethics. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation.—The term "solicitation" in the Principles means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition.—Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The Principles of Medical Ethics are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public. ■

Let These Guides Help You

The following guides and manuals have been prepared or obtained at the direction of the Council and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

- **Guide to the Service Corporation Law**

- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.

- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.

- **National Health Planning and Resources Act of 1974 (PL 93-641)**—Sets up a nationwide network of regional Health Services Areas and Health Systems Agencies.

- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.

- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.) (Also appears in this issue.)

- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)

- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10″ x 11½″. For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)

- **Physician and Hospital Records: Retention and Inspection**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.

- **Legal Responsibilities of the Physician-Patient Relationship.**

- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.

- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S Crelin and reprinted by permission of *American Scientist.*

- **Advertisements on Health Care Costs**—County Medical Societies may obtain upon request reproduction proof's on using health care costs for placement in their local newspapers.

- **Rubella—Red Measles Brochure**—This conveniently sized 2½″ x 4″ sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.

- **To Your Good Health**—Explains the reasons behind rising health care costs and offers tips on how to save money on medical expenses.

- **Alcohol and Your Unborn Child**—Warns women of the harmful effects of alcohol on an unborn child. (Available later this summer).

GOALS OF THE STATE MEDICAL SOCIETY OF WISCONSIN–1978

THE STATE MEDICAL SOCIETY of Wisconsin, to achieve the purpose set forth in Article II of its Constitution, seeks to:

I. **Attain and maintain the highest possible quality of health service for the people of Wisconsin**
II. **Establish a professional and socio-economic atmosphere conducive to quality care**
III. **Represent and serve the professional and practice needs of its members**
IV. **Maintain a united and capable membership organization so as to effectively achieve the Society's goals**

Within each of these goals are a number of objectives, and these are implemented by projects—each with impact on timetable, priorities, staffing and resources.

The Council at a two-day seminar in Wausau in September 1977 undertook an in-depth review of SMS goals, objectives, and projects, with assistance from the management consulting firm of Lawrence-Leiter. At that meeting the Council identified three major objectives and 21 projects which it considered to be of significant interest or concern. As a consequence of the Wausau seminar and following discussions with several Society officers, the staff developed a comprehensive statement of the total goals, objectives, and projects of the Society as these were perceived to have been authorized or proposed. This statement—including four goals, 25 objectives, and 128 projects—was accepted by the Council on December 10, 1977 as a working document to be modified and refined on a continuing basis. It subsequently was distributed to the House of Delegates at the April 1978 Annual Meeting.

GOALS—OBJECTIVES—PROJECTS	COMMITTEE RESPONSIBLE
GOAL I: ATTAIN AND MAINTAIN THE HIGHEST POSSIBLE QUALITY OF HEALTH SERVICE FOR THE PEOPLE OF WISCONSIN	
Objective 1: Positively influence the selection and training of competent, compassionate physicians in Wisconsin	Commission on Continuing Medical Education (CCME)
Project A: Maintain and expand liaison with the deans and faculties of both medical schools	CCME and Commission on Health Planning (CHP)
Project B: Assist deserving medical students with long-term, low interest loans	CES Foundation (CESF)
Project C: Encourage and support the Medical Student Summer Externship Program	CESF
Project D: Encourage the Legislature and the public to provide appropriate financial and policy support for the two medical schools and other educational institutions providing training for physicians and allied health personnel	Govermental Affairs Commission (GAC); CCME; CHP
Objective 2: Promote and strengthen the competence of physicians through Continuing Medical Education (CME)	CCME
Project A: Annual Scientific Meeting	CCME
Project B: Involve specialty societies and the two medical schools in the Annual Meeting and other scientific educational efforts	CCME
Project C: Local or regional CME Programs C1: Green Bay—September/October C2: Madison—November/December C3: Wausau—October/November C4: Eau Claire—March/May	CCME

Project D: Accreditation of CME programs of hospitals, county medical societies, specialty societies, voluntary health organizations (27 groups accredited—goal is 50 by end of 1978) D1: Liaison with Medical Examining Board on CME credits D2: Relationships with national Liaison Committee on Continuing Medical Education (LCCME)	Commission on CME
Project E: Cooperate with the state's PSROs and develop appropriate CME responses to various peer review activities	CCME
Project F: Provide CME support to the efforts of Commissions on Peer Review (CPR) and Mediation and Professional Ethics (CMPE) to rehabilitate physicians	CCME
Project G: (Project 19-Wausau) Establish statewide peer review through a foundation	Council WHCRI—CPR
Project H: Publication of *Wisconsin Medical Journal* H1: Annual BLUE BOOK Issue	WMJ Editorial Board
Project I: Individual practice audit or analysis (under discussion)	CCME
Project J: Investigate and review the appropriate role of the two medical schools in CME	CCME
Project K: Scientific Speakers Service	CCME/CES Foundation
Project L: Liaison with state Medical Education Review Committee (MERC)	CCME
Objective 3: Maintain and improve publicly and professionally acceptable programs of self-regulation and accountability	Comm on Mediation and Professional Ethics (CMPE) Comm on Peer Review (CPR)
Project A: Offer the public and profession an effective procedure for prompt and fair resolution of complaints regarding professional conduct and competence	CMPE
Project B: Same as A, but for evaluation of patterns of practice involving the appropriateness or competence of care, and provide adequate remedies or rehabilitation when peer standards are not met	CPR
Project C: Initiate prompt, fair and effective discipline of physicians as necessary; and where necessary advise patients of their responsibilities for medical care circumstances	CMPE
Project D: Conduct an effective Impaired Physician Program	CMPE
Project E: (Project 21-Wausau) Publicize work related to the impaired physician effort	CMPE and Commission on Public Information (CPI)
Project F: Increase liaison with state Medical Examining Board to more promptly and effectively discipline physicians whose conduct or performance is less than expected by peers	CMPE/CPR
Project G: Develop guidelines for advertising by physicians	CMPE
Project H: Interprofessional Code (Medicine-Bar)—published in 1977 periodic update, and act as mediation body in cases of dispute	CMPE
Project I: Work closely with WHCRI, FMCE and WisPRO to develop and implement effective peer review for both private and publicly reimbursed medical care services	CPR

Project J: Provide peer review assistance, in cooperation with WHCRI on a trial basis, for the Governor's Nursing Home Ombudsman Program — CPR

Objective 4: Provide leadership in the development of appropriate numbers, types and qualifications of allied health personnel, and their working relationships with physicians — Comm on Health Planning (CHP)

Project A: Monitor, evaluate and offer leadership concerning the appropriate use of physicians assistants (and similar personnel) under Wisconsin laws in ways to best serve the delivery of health care services — CHP

Project B: Properly implement the "Joint Practice Guidelines" developed by nursing and medicine in Wisconsin; monitor and periodically evaluate and update — Joint Practice Committee

B1: Monitor new developments in delivery of nursing services

Project C: Maintain close liaison with and provide medical guidance to the American Association of Medical Assistants, Wisconsin Society — 3 Medical Advisors/Assigned staff

Project D: Maintain continuing dialogue with the Wisconsin Physical Therapy Association to develop understanding and improved working relationships between MDs and PTs — CHP

Objective 5: Apply sound medical concepts to community health care activities designed to improve the quality of life for Wisconsin citizens

Project A: Support (or oppose) legislation to protect and improve the health of the people of the state — Governmental Affairs Commission (GAC)—others

A1: Drunk driving laws—Special session AB 1
A2: Child abuse reporting—SB 414
A3: Genetic testing—AB 299
A4: Minors consent for treatment—SB 296
A5: State catastrophic health insurance plan—AB 194
A6: Statewide emergency telephone number—SB 411
A7: State financial aid to HSAs—AB 782
A8: School immunization checkpoints—AB 727
A9: Home health care insurance—AB 498
A10: Raise drinking age to 19—SB 126
A11: Financial aid to hemophiliacs—AB 426
A12: Oppose repeal of helmet law—AB 222
A13: Insurance premium loans for the unemployed—AB 406

Project B: Assist physicians and public toward a better understanding of the process of aging, and seek to achieve the best possible health care for the aged, including nursing home care — Cmte on Aging and Extended Care Facilities (CAECF)

B1: Evaluate complaints about nursing home care
B2: Determine role of SMS in the entire spectrum of the care of the aging
B3: Advise Department of Health and Social Services (DHSS) on new quality control measures for long-term care facilities

Project C: Assist in the prevention, treatment and rehabilitation of persons affected by alcoholism and other drug abuse — Cmte on Alcoholism and Other Drug Abuse (CAODA)

C1: Support appropriate legislation in this field
C2: Encourage reduced prescription of amphetamines or methaqualones except for clear and acceptable medical uses
C3: Support alcoholism recognition and treatment programs

Project D: Develop and implement effective physician and public education or service programs regarding cancer — Cmte on Cancer (CC)

- D1: Assist in development of tumor registry programs
- D2: Distribute educational materials regarding cancer
- D3: Develop cancer continuing education programs for MDs
- D4: Oppose legalization of laetrile, and use of thermography as a sole diagnostic tool
- D5: Monitor current treatment modalities and trends, including the non-scientific
- D6: Liaison with American Cancer Society, Wisconsin Division, and Wisconsin Clinical Cancer Center

Project E: Concern with pregnancy, childbirth and children; with special emphasis on reduction of maternal mortality and prevention of disease or disability in children — Cmte on Maternal and Child Health (CMCH)

- E1: Continuing studies of maternal deaths in Wisconsin — Maternal Mortality Study Cmte (MMSC)
- E2: Scientific programs for physicians
- E3: Analysis and comment on proposed DHSS Child Health (Title V) State Plan
- E4: Develop patient leaflet and physician information program on fetal alcohol syndrome

Project F: Promote recognition of spiritual values in health care — Cmte on Medicine and Religion (CMR)

- F1: Annual breakfast program on medicine and religion
- F2: MD speakers bureau for clergy, physicians and churches
- F3: Develop hospital medical staff conferences on this topic
- F4: Promote increased dialogue between physicians and clergy

Project G: Promote recognition of mental health as an equal part of the patient's well-being — Cmte on Mental Health (CMH)

- G1: Support or oppose legislation in this area
- G2: Review and evaluate function and methodology of the committee
- G3: Review and revise Chapter 51, State Mental Health Act

Project H. Concern for the health and safety of persons in relation to their occupations — Cmte on Occupational Health (COH)

- H1: Periodically update, publish, and distribute the "Guidelines for Physicians and Nurses in Occupational Health"
- H2: Serve as advisory group to the state's Worker's Compensation Program

Project I: Concern for the health of those attending public or private schools, and maintain liaison with private and governmental agencies concerned with school health — Cmte on School Health (CSH)

- I1: Work Week of Health Programs—Auxiliary
- I2: (Project 18-Wausau) Upgrade medically related course curriculum in Wisconsin schools
- I3: Advisory services to the Wisconsin Interscholastic Athletic Association
- I4: Periodically review and revise the "School Health Examination" guide for physicians and school authorities
- I5: Advice to Department of Public Instruction (DPI) on implementation of laws regarding special education for the developmentally disabled
- I6: Representation on DPI Health Education Problems Committee (Dr Treffert—Mrs Smigielski)

Project J: Concern for the health and safety of those who use vehicles of transportation J1: Serve as medical advisory body to Department of Transportation (Motor Vehicle Division) on medical aspects of licensing motor vehicle operators J2: Support use of seat belts J3: Support stronger drunk driving laws	Cmte on Safe Transportation (CST)
Project K: Jail Health Care Studies—Law Enforcement Assistance Association (LEAA) AMA grant K1: Evaluation of health care conditions in selected jails K2: Accreditation of several Wisconsin county jails for the purpose of creating "model" jail health care programs K3: Assist AMA/LEAA in development of national jail health care standards K4: Study special needs of women inmates in jails	Special Cmte on Jail Health Care
Project L: Develop sound health screening and immunization policies and practices	Task Force on Health Screening and Immunization
L1: Develop preventive medical approaches to health care L2: Develop uniform immunization guidelines for children and adults L3: Develop health screening guidelines for all ages L4: Support statewide immunization efforts, including immunization "awareness" program L5: Find and implement solution to professional liability problems related to public immunization clinics L6: Liaison with EPSDT program—Early and Periodic Screening, Diagnosis and Treatment	Comm on Public Information
Project M: Joint study of "unnecessary surgery" with DHSS	Council/WHCRI-WRMP
Project N: "Brain death" definition for Legislature	Governmental Affairs Comm
Project O: Develop and implement an effective and influential committee activity and program relating to environmental health	GAC
Project Q: Food and Nutrition—SMS participate in statewide food and nutrition education program—representative to be selected by Council	Council

GOAL II: ESTABLISH A PROFESSIONAL AND SOCIO-ECONOMIC ATMOSPHERE CONDUCIVE TO QUALITY CARE

Objective 1: Exercise an essential role in the health planning decision-making process, especially as that planning impacts on availability, accessibility, quality and cost	Commission on Health Planning (CHP) Physicians Alliance Commission (PAC)
Project A: Influence the State Health Coordinating Council (Health Policy Council) and Designated Health Planning Agency (Department of Health and Social Services) toward medically acceptable health care planning A1: Plan review A2: Health Policy Council committees	CHP/PAC
Project B: Seek to effectively influence federal health planning legislation and regulation B1: Oppose proposed federal guidelines for health planning—December 9 deadline B2: Review and comment on proposed regulations re PL 93-641 to be issued by January 15, 1978	CHP/PAC

Project C: Assist physicians to be influential in the 7 HSA area decisions regarding planning C1: Audio-visual presentations to county societies and other MD groups C2: Develop Physician Health Task Forces to plan, anticipate, monitor, be involved in HSA activity C3: Health System Plan (HSP) and Annual Implementation Plan (AIP) review for each HSA	CHP/PAC
Project D: Influence Certificate of Need (CON) policy and administration to best protect the public and physicians	PAC
Objective 2: Play an essential role in decisions relating to voluntary or state and national standards for health care facilities and services	Comm on Health Planning (CHP)
Project A: Advocate and interpret for physicians the provisions of JCAH as they affect services to hospitalized patients; aid in the development of single, joint JCAH-state licensing inspections	CHP
Project B: H-38 laboratory rules	
Project C: H-24 hospital rules	
Project D: H-32 nursing home rules	
Objective 3: Develop new and effective ways to help contain the costs of medical and health care in a rising economy	Cmte on Evaluation of Delivery and Cost of Medical Care (CEDCMC)
Project A: Identify and implement specific role of physician in cost containment	CEDCMC
Project B: Consider means to bring greater equity for physicians and public to the fee systems of MDs	CEDCMC
Project C: Cooperate with AMA, other health organizations, insurance, business, labor, consumers, in ways to contain costs	CEDCMC
Project D: (Project 20-Wausau) Continue to review and develop medical cost data	CEDCMC
Project E: Consider cooperation with joint cost containment effort announced by AMA/American Hospital Association/Federation of American Hospitals on November 5, 1977	Council
Project F: Eliminate geographic discrimination in MD charges (reimbursement)	CEDCMC
Objective 4: Continue to study and seek solutions for problems of distribution of health personnel, availability and access	Comm on Health Planning (CHP) Cmte on Rural Health (CRH)
Project A: Rural health—primary care, FP problems	CRH
Project B: Physician-community recruitment booth at Annual Meeting	CRH
Project C: Physician Placement Service of SMS	CRH
Project D: Rural health conference (under consideration)	CRH
Project E: Emergency room services	CHP
Project F: Attract and retain more physicians in Wisconsin for residency training	CHP/CRH

Objective 5: Protect, promote and achieve the socio-economic interests of the members of SMS — Physicians Alliance Commission (PAC)

Project A: Act as advocate for the SMS members and patients in relation to third party payors — PAC

- A1: Assist the member in obtaining full and reasonable reimbursement for services appropriately provided
- A2: Oppose undue interference by third party payors in the doctor-patient relationship
- A3: Assist the member in obtaining for his/her patient the benefits afforded by a contract of insurance, health care plan or government program
- A4: Help assure a member of due process, protection from harassment, freedom from unnecessary paperwork and red tape in serving the patient with quality medical care and obtaining proper reimbursement
- A4a: Negotiate with DHSS/EDS re T-19 administration
- A5: Protect physician-patient interests in relation to Medicare, Medicaid and other government programs
- A5a: Conclude the successful suit against the Governor's T-19 fee freeze of December 23, 1974
- A5b: Satisfactorily resolve problems of Medicaid reimbursements to physicians
- A5c: Negotiate with DHSS re T-19 contract, certification and administrative rules
- A6: Oppose and remedy third party misrepresentation of physicians' charges, services, etc to the patient
- A7: Positively impact on cost containment activities of all third party payors
- A8: Positively impact on quality assurance-peer review activities of all third party payors

Project B: Seek to obtain more equitable reimbursement of physicians under Medicare and Medicaid (since payment levels are interrelated) — PAC

- B1: Single geographic charge area vs 10 charge areas—geographic discrimination
- B2: Possible HEW waiver to Wisconsin for new reimbursement plan for MDs
- B3: Proper use of procedure codes and their conversion by Medicare or Medicaid without adverse effect on reimbursement amount

Objective 6: Seek to assure computer data integrity and patient confidentiality in properly recording MD services and charges (the data are used as basis for investigations of fraud or abuse) — PAC

Objective 7: Develop economic research and analysis capacity re health care costs and utilization, especially as to physician services — PAC

Project A: Gather income-expense data re MD practices

Project B: Develop options to DHSS views for revamping CUR payment of MD fees in T-19

GOAL III: REPRESENT AND SERVE THE PROFESSIONAL AND PRACTICE NEEDS OF SMS MEMBERS

Objective 1: Effectively impact on state or federal legislation so as to secure the best interests of the public and the medical profession	Governmental Affairs Commission (GAC)
Project A: Build a sound, working political base with legislators and the political system A1: Frequent local meetings of physicians and legislators A2: Direct involvement of MDs and Auxiliary in the political process	PAC/WISPAC
Project B: Initiate and respond to legislation to achieve the goals of SMS and its members B1: 200+ bills in the 1977-78 session B2: Effective lobbying activities, involving MDs and Auxiliary as well as staff	GAC
Project C: Initiate and maintain effective Physicians Alliance Committees in each county medical society and Auxiliary for legislative, political and socio-economic purposes	PAC
Objective 2: Assure adequate professional liability protection for physicians at reasonable cost	
Project A: Exert all necessary influence on the policies and programs of WHCLIP (Wisconsin Health Care Liability Insurance Plan) and PCF (Patient Compensation Fund) to assure proper coverage, rates, etc.	PAC
Project B: Assist SMS members in obtaining adequate professional liability coverages through reliable sources	PAC
Project C: Assist SMS members in their administrative problems with liability insurors	PAC
Project D: Pursue amicus curiae regarding challenge to WHCLIP	PAC
Project E: Medical Defense Committee (MDC) activity in countersuits or lack of good faith defense	PAC/MDC
Project F: Consider development of SMS owned or sponsored professional liability plan	Cmte on Economic Medicine/PAC
Project G: Propose and seek to obtain tort changes	PAC
Project H: Monitor professional liability experience in Wisconsin in detail	PAC
Project I: Develop appropriate malpractice education-prevention programs for SMS members	PAC
Project J: Continuingly publicize the professional liability issue	PAC/Public Information
Objective 3: Develop and implement effective negotiating or collective bargaining capability on behalf of SMS members	PAC
Project A: Negotiating Seminar March 1978	PAC
Objective 4: Assure physicians of proper representation in every aspect of health care delivery	
Project A: Seek to involve members in HSAs	CHP

Project B: Resolution of disputes between medical staffs of hospitals and hospital administration or boards of directors, or disputes of members with other care institutions — CHP/PAC

- B1: Practice privileges
- B2: Representation on the hospital board
- B3: JCAH accreditation related matters
- B4: Nonmedical staff overriding MD orders
- B5: Hospital employed physicians and private practitioners
- B6: Hospital owned satellites
- B7: Issues affecting compensation, proper practice or working conditions, adequacy of equipment, competence, reliability and availability of nonmedical aides and assistants, and interference in physician-patient relationship

Project C: (Project 15-Wausau) Establish relationships with various counterpart groups — PAC

Objective 5: Maintain and improve membership services

Project A: Continue and improve personal and office insurance plans for members (reevaluate and rebid periodically) — Council Cmte on Economic Medicine (CEM)

- A1: Life
- A2: Health
- A3: AD&D
- A4: Time loss
- A5: Office overhead
- A6: Non-professional, general liability
- A7: Other (Worker's Compensation, leased auto, etc)

Project B: Insurance checklist for MDs — CEM

Project C: Medical-legal advice on continuing basis — Assigned staff/SMS general counsel

Project D: Physicians Placement Service — Assigned staff

Project E: Practice Management Services — To be determined by Council

- E1: Develop and implement use of AMA uniform claim form and uniform procedure and diagnostic codes — PAC
- E1a: Uniform claim form committee, T-19
- E1b: Code and profile conversion committee, T-19
- E1c: Supplies and equipment coding committee, T-19
- E2: Computer services
- E3: Office personnel training
- E4: Third party claims consultation
- E5: Office practice aids

Project F: Physicians Directory issue of WMJ (under consideration) — WMJ Board, Council

Project G: Other services with alternative income opportunities (under consideration by Council Finance Committee) — CFC

Project H: Closer liaison with clinic managers — Secretary/PA

Objective 6: Expand and improve communications

Project A: Improve external communications to tell MD/SMS story to the public and positively affect the doctor's "image" — Commission on Public Information (CPI)

- A1: Media relations
- A2: Special efforts with TV

A3: Radio Public Service Announcement series
A4: Conferences with editors and staffs
A4a: Media-Physician Forum—Eau Claire
A5: (Project 9-Wausau) Public information liaison at county level
A6: (Project 10-Wausau) Establish Society posture through position papers
A7: (Project 17-Wausau) Investigate prospect of using PR firm
A8: Brochure series—costs of health care; rights and responsibilities
A9: Support of TV anti-violence efforts

Project B: Improve internal communications — CPI
B1: *Leaders' Letter*—weekly
B2: *Capitol Week*—weekly — (GAC)
B3: GREEN SHEET—monthly
B4: Special membership mailings
B5: Brochures re membership advantages
B6: Field staff to members — (PAC)
B7: Madison staff to field staff — Secretary/Assigned staff
B8: (Project 11-Wausau) Schedule Council meetings throughout state — Council/Assigned staff
B9: (Project 12-Wausau) Solicit proposals for incoming WATS and "Hot Line" — Council/Assigned staff
B10: (Project 14-Wausau) Publish meeting dates for related medical affairs — Council/Assigned staff
B11: Intra-office Friday memo on upcoming travel, conferences, meetings of all staff — Assigned staff
B12: Resident "Housestaff Forum"
B13: Improve WMJ as an organizational communicator
B14: Revision of "new member packet"

GOAL IV. MAINTAIN A UNITED AND CAPABLE MEMBERSHIP ORGANIZATION SO AS TO EFFECTIVELY ACHIEVE THE SOCIETY'S GOALS

Objective 1: Unite all members of the SMS for their mutual benefit and protection; preserve and promote the individual freedom of judgment and action so essential to their success as professionals — Council/PAC/others

Project A: Improve involvement with specialty groups
A1: Review current involvement and suggest changes
A2: (Project 13-Wausau) Create liaison group to establish relations with specialty societies — Council/Executive Cmte (EC)
A3: Provide administrative and other services to specialty societies — Council/EC

Project B: Support and promote the unity of county-state-AMA as the federation of organized medicine

Objective 2: Increase participation by SMS membership

Project A: Periodic membership surveys of opinion/attitudes; second survey completed
A1: Green Sheet or WMJ mini-surveys — PAC/WMJ

Project B: New member indoctrination — PAC

Project C: (Project 5-Wausau) Communicate committee openings to members — Secretary/Assigned staff

Project D: (Project 6-Wausau) Revise handbook section on county programs/meetings — Secretary/Assigned staff

Project E: (Project 7-Wausau) Review and revision of other county society handbook sections	Secretary/Assigned staff
Project F: (Project 8-Wausau) Improve liaison at hospital staff levels	SMS Council and officers/county society officers/Assigned staff
Objective 3: Expand and improve the quantity and quality of SMS membership	
Project A: Continue and improve membership retention and recruitment efforts	Comm on Public Information/Physicians Alliance Comm
A1: Develop strategies for retention; establish understanding and priorities for field consultants	Others
Project B: (Project 1-Wausau) Attract new members through two years dues reduction	Council Finance Cmte
Project C: (Project 2-Wausau) Personal visits to prospective new members	Field staff/members
Project D: (Project 3-Wausau) Use Auxiliary for new member recruitment	Auxiliary leadership/field staff
Project E: (Project 4-Wausau) Recruit new members through academia and residents	CPI/PAC
Project F: Develop effective resident housestaff liaison and services	PAC
F1: Regular newsletter	
F2: Regular meetings with residents	
F3: Representatives on committees and in House of Delegates	
F4: SMS staff assistance to housestaff	
Objective 4: Maintain and improve the resources necessary to operate an effective organization	Council
Project A: Provide all essential support services for the Society as an organization	Staff
A1: Maintain an effective Administrative Services Division to provide such services as accounting, member records, dues collection, purchasing, mail, printing, word processing, personnel, payroll, etc.	
Project B: Provide and maintain a sound fiscal position for SMS	Council Finance Cmte (CFC)
B1: (Project 16-Wausau) Pursue funding of projects through grant acquisition	CFC
B2: Expand alternative or supplemental sources of income/service	CFC
B3: Carry out House of Delegates directive regarding dues levels based on COL increases	CFC
Project C: Acquire, train and retain capable and efficient personnel to serve the Society's staff needs	
Project D: Provide appropriate facilities to serve as the Society's headquarters	SMS Realty Board of Trustees or Council/Assigned staff
D1: Develop policies and procedures for rental of 330 East Lakeside space after January 1, 1978	
D2: Remodeling of SMS building for energy control	
D3: Refurnishing Council room area	

Objective 5: Maintain and expand active role of Auxiliary in SMS affairs

Project A: Badger Doctor's Wife	Auxiliary
Project B: SMS staff the Auxiliary	Secretary/Assigned staff
Project C: Work Week of Health	Auxiliary
Project D: Auxiliary membership on SMS committees	Council/House of Delegates
Project E: Wide variety of community health and information efforts	Auxiliary
Project F: (Project 3-Wausau) Involve Auxiliary members in membership recruitment and retention	Auxiliary leadership
Project G: Involve Auxiliary members in legislative and political action activities	Auxiliary leadership

Objective 6: Develop and maintain an effective Charitable, Educational and Scientific Foundation — CESF

Project A: Aid to needy physicians	
Project B: Student loans	
Project C: Support for scientific education and research	
Project D: Operate Museum of Medical Progress (?)	
Project E: Develop and promote Aesculapian Society (AS) for preservation of medical history	CESF/AS
Project F: Develop adequate funding for CESF	CESF Board of Trustees/ Assigned staff

Objective 7: Provide an effective voice for Wisconsin physicians in the American Medical Association through a strong delegation (delegates and alternates) to the AMA House of Delegates. — House of Delegates/Council ■

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On July 1, 1977, the Liaison Committee on Continuing Medical Education (LCCME) assumed from the American Medical Association (AMA) the responsibility for accreditation of institutions and organizations offering continuing medical programs and for the approval of state and territorial medical associations to conduct Survey for Accreditation Programs, which provide recommendations to the LCCME on accreditation of intrastate institutions and organizations.

The LCCME is composed of the following member organizations:—American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Specialty Societies, Federation of State Medical Boards of the United States, Inc.

The State Medical Society of Wisconsin accreditation operates under the authority of the LCCME, of which the AMA is a member organization. Accreditation by the SMSW is equivalent to action by the LCCME. Following are the six categories of learning activities that are acceptable toward CME credit:

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical training.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

☆ ☆ ☆

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and LCCME for continuing medical education programming at April 1, 1978*

Adolf Gundersen Medical Foundation & La Crosse Lutheran Hospital, La Crosse
Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Deaconess Hospital, Milwaukee
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Methodist Hospital, Madison
Memorial Hospital, Menomonie
Osseo Area Municipal Hospital, Osseo
Sacred Heart Hospital, Eau Claire
Sauk Prairie Memorial Hospital, Prairie du Sac
St Agnes Hospital, Fond du Lac
St Clare Hospital, Baraboo
St Francis Hospital, La Crosse
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Vincent Hospital, Green Bay
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospitals, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

American Heart Association, Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
State Medical Society Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Critical Care Medicine
Wisconsin Society of Obstetrics & Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

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Dept CME, UW Medical School
Interstate Postgraduate Medical Association
Wisconsin Society of Anesthesiologists
The State Medical Society of Wisconsin

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Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to bring into one compact organization the entire medical profession of the state of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote open communication and understanding among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

*COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through April 1978.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors, immediate past president, president, president-elect, speaker and vice-speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Council, but without the right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members, and in March 1976 to add the president-elect and vice-speaker. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for

which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from eight districts, and a speaker and vice-speaker of the House of Delegates.

Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the approval and confirmation of the House of Delegates.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph; second paragraph amended in March 1973. Number of districts reduced from thirteen to eight in April 1975.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the eight districts, except that in any councilor district embracing a membership of 200 or more, there shall be elected one additional councilor for each additional 200 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965. Number of members used as basis for councilor representation changed from 250 to 200 in April 1975.

As nearly as possible, one-third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

SEC. 4. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds a license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such

membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election. Such resident members shall have the right to vote and hold office.

Sec. 5. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice. Except as otherwise provided in Section 14 of this Chapter, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

Sec. 6. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

Sec. 7. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

Sec. 8. *Honorary Membership.* Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

Sec. 9. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

Sec. 10. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, or who practices less than six (6) weeks per year, is eligible for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

Sec. 11. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

Sec. 12. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

Sec. 13. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the *Wisconsin Medical Journal,* and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

Sec. 14. *Nonresident Membership.* Any member who moves

to the jurisdictional area of another constituent association, while in dues-paid status, may be granted nonresident membership upon written request to and approval by the Council. A nonresident member shall have all the rights and privileges of regular membership except the rights to vote and hold office. This nonresident category shall require no involvement of a county medical society. Neither the time limit in paragraph 2, Section 5 of this Chapter nor the provisions of Chapter VIII shall apply to this Section. The annual dues shall be established by the Council.

SEC. 15. *Senior Membership.* Any member who has reached age 65 and practices 1,000 hours or less during a calendar year, but does not qualify for associate membership, may upon application, recommendation by the county medical society, and approval by the State Medical Society, be granted senior membership upon payment of 50% of regular member dues. Such change shall be effective January 1 following receipt of such request.

COMMENT: Section 13, added in May 1964; sections 14 and 15, in April 1978.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

COMMENT: Section 2 on publication of scientific papers rescinded in May 1972.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966; second paragraph of Section 2, below, amended in March 1973.

The term "full-paid members" as used in this section includes regular members of the Society, life members, affiliate members, associate members, educational members, resident members, honorary members, special service members, and members whose dues are waived or remitted by official action of the Society. Members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provision.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate for each district, except that in any councilor district embracing a membership of 500 or more, there shall be elected one additional delegate for each additional 500 members or major fraction thereof, and one delegate representing all of the specialty sections. This newly elected committee shall become operative at the close of the final meeting of that annual session, and shall function until the close of the final meeting of the following year's annual session. The incoming committee shall meet with the existing committee, but without vote, during the overlapping days of the annual session. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each

of the offices to be filled at the next annual session. No two candidates for president-elect shall be from the same district.

The Committee on Nominations shall convene at least two months prior to the annual session of the House of Delegates to prepare a slate of candidates. This meeting, to be held at the Society headquarters, shall include an open session of not less than one hour to allow individual nomination of candidates. Any vacancy occurring in the Committee on Nominations between the date of its election and the time of its reporting shall be filled by appointment by the councilor or councilors of the councilor district in which the vacancy occurs; provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot of the several section chairmen.

COMMENT: Section 1 amended in March 1973; first sentence of paragraph one further amended in April 1975; section further amended in March 1976.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. The House of Delegates shall elect the president-elect, speaker and vice-speaker of the House of Delegates, and delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the legal votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie for the lowest number of votes and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of *Wisconsin Medical Journal).*

In March 1973 the House reaffirmed the above and stated that as general manager, the secretary is in charge of all Society divisions, activities, and personnel.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and

other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the *Journal* and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice-chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMISSIONS AND COMMITTEES

SECTION 1. The Council shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary properly to conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers who are eligible for membership cannot be appointed or elected. Persons not eligible for membership in the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such committees or commissions. Such individuals shall not have a vote or the right to hold office.

Each commission and committee shall have the duty of keeping currently informed on matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities for improvement; of determining the best solutions it can to the specific matters referred to it; of contributing in its area to the achievements of the Society and its members in the protection and improvement of the quality of life for the whole human family; and finally, of making all its efforts useful by passing on to the Society's Council or House of Delegates in the most effective manner possible the results of its studies and activities with appropriate recommendations for action. In addition, each commission or committee shall represent the Society's interests by continuing contacts with voluntary and governmental agencies having related concerns with a view to coordinated efforts serving the best health interests of the people of Wisconsin.

SEC. 2. Specialty sections. The specialty sections shall be regarded as special committees of the Society to which the Council or any commission or committee may turn for advice and

assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of the talents available through these sections and their related specialty societies.

COMMENT: This Chapter repealed and re-created in April 1975; amended in 1978 as to membership.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall be deemed delinquent until his name is properly reported and his dues for the current year are properly remitted. The name of any member who has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before October 15 shall be removed from the active membership rolls of his county society and this Society until his name is properly reported and all his dues for the year of enrollment are properly paid.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure.

CHAPTER XI

COUNTY SOCIETIES

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 5. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 6. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 6, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC. 7. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 8. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SPECIALTY SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such specialty sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

SEC. 7. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VII of these Bylaws.

COMMENT: Section 7 added in April 1975.

CHAPTER XIII

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed. ■

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. The should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

Adopted June 7, 1957 ■

Life is short . . . Art is long . . . Experience is difficult

Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS. Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Funds for those loans have been given to the Foundation to administer according to the wishes of the donors.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has been highly successful. It provides a ten-week externship with a family physician for students who have completed their freshman year of medical school. Participating students receive fellowship grants from the Foundation.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering, and funding investigations of a scientific or medical soco-economic nature.

CONTINUING MEDICAL EDUCATION. Educational activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on such subjects as medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as many other medical subjects.

Since 1975, the continuing medical education programming of Wisconsin hospital and specialty groups has been accredited and supported by the Foundation.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor.

In addition, service can be provided to those who wish to establish a Living Trust by naming the Foundation as trustee. Use of this mechanism can result in an immediate tax advantage for the donor while providing a guaranteed income for life. The principal would revert to the Foundation upon death of the donor.

ALL TYPES OF CONTRIBUTIONS TO THIS FOUNDATION ARE TAX-DEDUCTIBLE.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy periodically publishes a newsletter that highlights the many contributions of medical memorabilia to the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 750 members now, it welcomes many more. The annual dues are only $5.00, payable to the CES Foundation—Academy of Medical History, Box 1109, Madison, Wis 53701.

COUNCILOR DISTRICTS AND COUNCILORS

District	Councilor
1	John P Mullooly, MD, Milwaukee
	Paul G LaBissoniere, MD, Wauwatosa
	Carl S L Eisenberg, MD, Milwaukee
	Elizabeth A Steffen, MD, Racine
	Wayne J Boulanger, MD, Milwaukee
	Daniel K Schmidt, MD, Milwaukee
	John J Foley, MD, Menomonee Falls
	William A Nielsen, MD, West Bend
	Irwin J Bruhn, MD, Walworth
2	Blake E Waterhouse, MD, Madison
	Richard W Edwards, MD, Richland Center
	William P Crowley, MD, Madison
	Allen O Tuftee, MD, Beloit
3	Cornelius A Natoli, MD, LaCrosse
4	John J Kief, MD, Rhinelander
	Russell F Lewis, MD, Marshfield
5	John U Peters, MD, Fond du Lac
	Timothy T Flaherty, MD, Neenah
6	Antoine Barrette, MD, Peshtigo
	Walter F Smejkal, MD, Manitowoc
7	Paul S Haskins, MD, River Falls
8	Joseph M Jauquet, MD, Ashland

THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

One of the many functions of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal*. This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis. 53701

Officers and Councilors 1978-1979

State Medical Society of Wisconsin

330 East Lakeside St (PO Box 1109), Madison, Wis 53701 • Tel 608/257-6781

Toll-free in Wisconsin: 1-800-362-9080

OFFICERS OF THE SOCIETY

PRESIDENT (1978-1979)
Jules D Levin, MD, 1530 West Spruce Court, Milwaukee 53217

PRESIDENT-ELECT (1978-1979)
Darold A Treffert, MD, Box H, Winnebago 54985

SECRETARY/GENERAL MANAGER
Earl R Thayer, 330 East Lakeside St, Madison 53701

TREASURER (1978-1979)
Eugene J Nordby, MD, 2704 Marshall Court, Madison 53705

SPEAKER (1977-1979)
Albert J Motzel Jr, MD, 1111 Delafield St, Waukesha 53186

VICE-SPEAKER (1978-1979)
Duane W Taebel, MD, 1836 South Ave, LaCrosse 54601

PAST PRESIDENT (1978-1979)
Roy B Larsen, MD, 2000 Westwood Drive, Wausau 54401

THE COUNCIL

CHAIRMAN
Paul S Haskins, MD, River Falls

VICE-CHAIRMAN
Timothy T Flaherty, MD, Neenah

COUNCILORS (by districts*)

FIRST: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

John P Mullooly, MD (1976-1979)
8430 W Capitol Dr, Milwaukee 53222

Paul G LaBissoniere, MD (1976-1979)
10425 W North St, Wauwatosa 53226

Wayne J Boulanger, MD (1978-1981)
324 E Wisconsin Ave, Milwaukee 53202

Daniel K Schmidt, MD (1978-1981)
720 E Wisconsin Ave, Milwaukee 53202

John J Foley, MD (1978-1981)
PO Box 427, Menomonee Falls 53051

William A Nielsen, MD (1978-1981)
PO Box 178, West Bend 53095

Irwin J Bruhn, MD (1978-1981)
Walworth 53184

Carl S L Eisenberg, MD (1977-1980)
3003 West Good Hope Rd
Milwaukee 53209

Elizabeth A Steffen, MD (1978-1981)
734 Lake Ave, Racine 53403

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

Blake E Waterhouse, MD (1976-1979)
30 S Henry St, Madison 53703

Richard W Edwards, MD (1976-1979)
1313 W Seminary St, Richland Center 53581

William P Crowley, MD (1978-1981)
20 S Park St, Madison 53715

Allen O Tuftee, MD (1976-1979)
1905 Huebbe Parkway, Beloit 53511

THIRD: Buffalo, Crawford, Jackson, Juneau, LaCrosse, Monroe, Trempealeau, Vernon Counties

Cornelius A Natoli, MD (1977-1980)
2760 Hagen Road, LaCrosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1977-1980)
1020 Kabel Ave, Rhinelander 54501

Russell F Lewis, MD (1977-1980)
1000 N Oak Ave, Marshfield 54449

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

John U Peters, MD (1976-1979)
505 E Division, Fond du Lac 54935

Timothy T Flaherty, MD (1977-1980)
547 E Wisconsin Ave, Neenah 54956

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Antoine Barrette, MD (1977-1980)
132 N Emery Ave, Peshtigo 54157

Walter F Smejkal, MD (1976-1979)
601 Reed Ave, Manitowoc 54220

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Paul S Haskins, MD (1977-1980)
409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Joseph M Jauquet, MD (1978-1981)
200 7th Ave West, Ashland 54806

Past President *Larsen*
President *Levin*
Speaker *Motzel*
President-elect *Treffert*
Vice-speaker *Taebel*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

CALENDAR YEARS 1977-1978

John E Dettmann, MD, 1751 Deckner Ave, Green Bay 54302

George E Collentine Jr, MD, 2388 N Lake Dr, Milwaukee 53211

Delore Williams, MD, 8501 W Lincoln Ave, West Allis 53227

CALENDAR YEARS 1978-1979

Gerald J Derus, MD, 5001 Monona Dr, Madison 53716

Henry F Twelmeyer, MD, 2500 N Mayfair Rd, Wauwatosa 53226

CALENDAR YEARS 1979-1980

Delore Williams, MD, 8501 W Lincoln Ave, West Allis 53227

Patricia J Stuff, MD, PO Box 522, Bonduel 54107

John K Scott, MD, 1605 Monroe St, Madison 53711

ALTERNATE DELEGATES TO THE AMA

CALENDAR YEARS 1977-1978

George A Behnke, MD, 1107 Riverside Dr, Kaukauna 54130

Harold J Kief, MD, Rte #1, Box 1502 Rhinelander 54501

Patricia J Stuff, MD, PO Box 522, Bonduel 54107

CALENDAR YEARS 1978-1979

Warren H Williamson, MD, 500 Walton, Racine 53402

John R McKenzie Jr, MD, 415 S Meadow, Oshkosh 54901 (for year 1979 to complete John K Scott, MD term as alternate)

CALENDAR YEARS 1979-1980

John D Riesch, MD, PO Box 427, Menomonee Falls 53051

Cornelius A Natoli, MD, 2760 Hagen Rd, LaCrosse 54601

Richard W Edwards, MD, 1313 W Seminary St, Richland Center 53581 ■

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*Map indicating location of districts, opposite page.

Note: Officers, councilors, delegates, and members of Commissions and Committees are elected at the Annual Meeting (April 1978). Dates in parentheses indicate beginning and expiration of term of office.

AMA Delegates and Alternates' terms of office are on a calendar basis, although elected at the Annual Meeting.

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Commissions and Committees—1978-1979

State Medical Society of Wisconsin

330 East Lakeside St (Box 1109), Madison Wis 53701 • Tel 608/257-6781

Toll-free in Wisconsin: 1-800-362-9080

COMMISSIONS

COMMISSION ON CONTINUING MEDICAL EDUCATION

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the annual meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

Warren J Holtey, MD, Marshfield, 1979 *Chairman*

Bradley G Garber, MD, Osseo, 1979

William E Hein, MD, Green Bay, 1979

Martin Z Fruchtman, MD, Waukesha, 1980

Joseph C Darin, MD, Milwaukee, 1980

George A Berglund, MD, Milwaukee, 1980 *Vice-chairman*

Donald C Whitenack, MD, LaCrosse, 1981

John L Raschbacher, MD, Waukesha, 1981

Leonard H Wurman, MD, Wausau, 1981

COMMISSION ON GOVERNMENTAL AFFAIRS

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government; coordination of county legislative committees required by the Bylaws.

Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval by the Council. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote.

Thomas P Belson, MD, Waukesha, 1979

Theodore C Fox, MD, Antigo, 1979

J D Kabler, MD, Madison, 1979 *Vice-chairman*

Robert F Purtell, Jr, MD, Milwaukee, 1980

Jack D Edson, MD, Eau Claire, 1980

Raymond C Zastrow, MD, Wauwatosa, 1980

Joseph M Lubitz, MD, Oconomowoc, 1981 *Chairman*

Martin L Janssen, MD, Friendship, 1981

Ralph L Suechting, MD, Neenah, 1981

The Commission also has a voting representative from each of the specialty sections of the Society, and several subcommittees appointed by the Commission chairman.

COMMISSION ON HEALTH PLANNING

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

Edward J Lennon, MD, Milwaukee, 1979

Bruce J Stoehr, MD, Green Bay, 1979

Dale V Moen, MD, Shell Lake, 1979

Marvin G Parker, MD, Racine, 1980

Donald R Korst, MD, Madison, 1980

Frederic L Hildebrand, MD, Neenah, 1980

John D Hart, MD, Shawano, 1981

Guenther Pohlmann, MD, Milwaukee, 1981

D Joseph Freeman, MD, Wausau, 1981

COMMISSION ON MEDIATION AND PROFESSIONAL ETHICS

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, and when it deems necessary to recommend to the Council disciplinary or other action as appropriate. It shall also be concerned with matters of interprofessional conduct, including development of appropriate codes of interprofessional relations, and advise and consult with component societies on problems of ethics and discipline in concert with members of the Council whose responsibilities for this area are specified in the Bylaws.

Michael McCormick, MD, Waukesha, 1979

Owen E Larson, MD, Neenah, 1979

John Wear, Jr, MD, Madison, 1979

Charles E Koepp, MD, Marinette, 1980

Herman J Dick, MD, Sheboygan, 1980

Harry F Weisberg, MD, Milwaukee, 1980

Gerald C Kempthorne, MD, Spring Green, 1981 *Chairman*

G John Weir, Jr, MD, Marshfield, 1981

Brian T Coffey, MD, Racine, 1981 *Vice-chairman*

COMMISSION ON PUBLIC INFORMATION

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

Herbert F Sandmire, MD, Green Bay, 1979

Charles Sorensen, MD, Wisconsin Rapids, 1979

S J Graiewski, MD, Oshkosh, 1979

Joseph W Edgett, Jr, MD, LaCrosse, 1980

Mark J Popp, MD, Brookfield, 1980

William B Gallagher, MD, LaCrosse, 1980

Richard W Shropshire, MD, Madison, 1981

Wallace MacMullen, MD, Green Bay, 1981

Richard A Henry, MD, Chippewa Falls, 1981

Chairman and vice-chairman of commissions and committees are elected at the first meeting following the Annual Meeting. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

COMPLETE

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COMMISSION ON PEER REVIEW

This commission may have up to twenty-five members. It shall initiate, explore, and bring to the attention of the Council suggested policies and programs relating to peer review in Wisconsin; serve as the advisory and coordinating body within the Society for the development of a statewide basis of medical peer review, including utilization review, appropriateness of care, services and fees, and quality assurance, and the establishment of local and/or district peer review committees; serve as the initial appellate body for peer and utilization review in the state to consider cases appealed from local committees involving the quality and utilization of medical care; function as the medical component for implementation of peer review under Wisconsin Health Care Review, Inc., and as the Society's advisory body on PSRO.

Erwin O Hirsch, MD, Milwaukee, 1979
Chairman
Edwin W Hoeper, MD, Marshfield, 1979
Ronald J Darling, MD, Waukesha, 1979
Richard W Edwards, MD, Richland Center, 1979
Leo Grinney, MD, Racine, 1979
John Erbes, MD, Milwaukee, 1979
Charles Mann, MD, Madison, 1979
Rocco Latorraca, MD, Cudahy, 1980
Robert E Johnston, MD, Green Bay, 1980
Vice-chairman
Richard Logan, MD, Madison, 1980
Melvin F Huth, MD, Baraboo, 1980
Mark Lochner, MD, Waupaca, 1980
William D James, MD, Dousman, 1980
David Westgard, MD, LaCrosse, 1980
John B McAndrew, MD, Oshkosh, 1981
Lloyd R Cotts, MD, Rice Lake, 1981
John Flannery, Jr, MD, Wausau, 1981
Joseph B Grace, MD, Green Bay, 1981
James M Huffer, MD, Madison, 1981
Thomas Jennings, MD, West Allis, 1981
John D Riesch, MD, Menomonee Falls, 1981

PHYSICIANS ALLIANCE COMMISSION

This commission shall have 18 members consisting of one for each Councilor District, except that District 2 shall have two members and District 1 shall have seven members. In addition, the President of the State Medical Society, the Chairman of the Council, and Chairman of the Commission on Governmental Affairs will be ex officio members with vote. Nominations for membership on the commission shall be made by the Council Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Council at every regular meeting and annually to the House of Delegates, both as to its operations and policy recommendations.

Kenneth M Viste, Jr, MD, Oshkosh, 1979
Chairman
Rudy P Froeschle, MD, Waukesha, 1979
Leonard B Torkelson, MD, Baldwin, 1979
Harry H Larson, MD, Ashland, 1979
Robert Kitzman, MD, Rhinelander, 1979
LaVern H Herman, MD, Waukesha, 1980
Paul A Jacobs, MD, Milwaukee, 1980
Charles E Pechous, Jr, MD, Kenosha, 1980
Jordon Frank, MD, Beloit, 1980
Vice-chairman
Charles N Ford, Jr, MD, LaCrosse, 1980
Russell Quirk, MD, Racine, 1981
Frederick C Kriss, MD, Madison, 1981
Joseph C Diraimondo, MD, Manitowoc, 1981
John F Just, MD, Milwaukee, 1981
Richard Stone, MD, Milwaukee, 1981

Ex officio voting members:
President, State Medical Society
Chairman of the Council
Chairman, Commission on Governmental Affairs

WISCONSIN MEDICAL JOURNAL

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

Editorial Board

Victor S Falk, MD, Edgerton, 1980
Chairman and Medical Editor
Wayne J Boulanger, MD, Milwaukee, 1979
Harold H Scudamore, MD, Monroe, 1979
Melvin F Huth, MD, Baraboo, 1980
Garrett A Cooper, MD, Madison, 1980
Richard D Sautter, MD, Marshfield, 1981
M C F Lindert, MD, Milwaukee, 1981

Editorial Associates (appointed annually by Council)

Wayne J Boulanger, MD, Milwaukee
Chairman and Editorial Director
John P Mullooly, MD, Milwaukee
T H McDonell, MD, Waukesha
Philip J Dougherty, MD, Menomonee Falls
Raymond A McCormick, MD, Green Bay
Brenton H Field, Jr, MD, Milwaukee

COMMITTEES

COMMITTEE ON AGING AND EXTENDED CARE FACILITIES

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Elston L Belknap, Jr, MD, Madison, 1979
Donald J Heyrman, MD, Menomonee Falls, 1979
William B Potos, MD, Cudahy, 1979
Joseph Springberg, MD, Beloit, 1980
Frederick W Blancke, MD, Madison, 1980
Gertrude Howe, MD, Fish Creek, 1980
Nicholas L Owen, MD, Milwaukee, 1981
W E Rosenkranz, MD, Mukwonago, 1981
John E Thompson, MD, Nekoosa, 1981

COMMITTEE ON ALCOHOLISM AND OTHER DRUG ABUSE

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Alan E Reed, Jr, MD, Wauwatosa, 1979
Marwood E Wegner, MD, St Croix Falls, 1979
Duane Taebel, MD, LaCrosse, 1979
Darold A Treffert, MD, Winnebago, 1980
Eugene J Kinder, MD, Spring Green, 1980
Edward C Schmidt, MD, Milwaukee, 1980
Ronald L Harms, MD, Shawano, 1981
Warren H Williamson, MD, Racine, 1981
Fred H Koenecke, MD, Madison, 1981

COMMITTEE ON CANCER

This committee shall be concerned about the cause, diagnosis, prevention, and alleviation of human cancer.

John K Scott, MD, Madison, 1979
Donald A Jeffries, MD, Shawano, 1979
Marcia Richards, MD, Milwaukee, 1979
Glenn A Smiley, MD, Delavan, 1980
Ralph C Frank, MD, Eau Claire, 1980
James J Tydrich, MD, Richland Center, 1980
John D Hurley, MD, Milwaukee, 1981
Robert E Carlovsky, MD, Fond du Lac, 1981
John J Smalley, Jr, MD, LaCrosse, 1981

COMMITTEE ON MATERNAL AND CHILD HEALTH

This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Kilian H Meyer, MD, Richland Center, 1979
Edward Buerger, MD, Waukesha, 1979
Curtis R Weatherhogg, MD, Madison, 1979
Vice-chairman
David V Foley, MD, Milwaukee, 1980
James C Tankersley, MD, LaCrosse, 1980
John E Inman, MD, Monroe, 1980
Richard C Brown, MD, Eau Claire, 1981
Walter R Schwartz, MD, Wauwatosa, 1981
Chairman
Raymond E Burrill, MD, Marshfield, 1981

COMMITTEE ON MEDICINE AND RELIGION

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

John O Simenstad, MD, Osceola, 1979
John S Harris, MD, Appleton, 1979
John P Mullooly, MD, Milwaukee, 1979
Maxwell Weingarten, MD, Milwaukee, 1980
John K Scott, MD, Madison, 1980
E Basil Jackson, MD, Milwaukee, 1980
Richard W Shropshire, MD, Madison, 1981
Frank J Cerny, MD, Fond du Lac, 1981
Roger Evans, MD, LaCrosse, 1981

COMMITTEE ON MENTAL HEALTH

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

David P Donarski, MD, Green Bay, 1979
William H Heywood, MD, Marshfield, 1979
Gerald C Kempthorne, MD, Spring Green, 1979
Francis M Forster, MD, Madison, 1980
Theodore J Nereim, MD, Mount Horeb, 1980
Charles W Landis, MD, Milwaukee, 1981
C E Moore, MD, Fond du Lac, 1981
Robert F Goerke, MD, Milwaukee, 1981

COMMITTEE ON OCCUPATIONAL HEALTH

This committee shall be concerned about the health and safety of persons in relation to their occupation. This shall include matters concerning Worker's Compensation.

Charles W Fishburn, MD, New Berlin, 1979
Donald M Rowe, MD, Kohler
William C Curtis, MD, Milwaukee, 1979
John T Bruton, MD, Racine, 1980
John W Faber, MD, Neenah, 1980
Louis Olsman, MD, Kenosha, 1980
Carl Zenz, MD, West Allis, 1981
Kenneth R Peters, MD, Menomonee Falls, 1981
Robert Dedmon, MD, Neenah, 1981

COMMITTEE ON RURAL HEALTH

This committee shall be concerned with the special problems related to assuring adequate medical and health care for those who live in rural areas.

George H Handy, MD, Madison, 1979
Walther W Meyer, MD, Medford, 1979
Robert A Starr, MD, Viroqua, 1979
Edward J Stack, MD, Superior, 1980
Timothy A Correll, MD, Dodgeville, 1980
Burton K Smith, MD, Wausau, 1980
Donald Welter, MD, Milwaukee, 1981
John J Beck, MD, Sturgeon Bay, 1981
Boyd Groth, MD, Mosinee, 1981

COMMITTEE ON SCHOOL HEALTH

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

James C H Russell, MD, Ft Atkinson, 1979
Vincent Savaglio, MD, Kenosha, 1979
Darrell Witt, MD, Wausau, 1979
William T Brodhead, MD, Madison, 1980
Frank Walker, MD, Brookfield, 1980
Lawrence K Siegel, MD, Waukesha, 1980
George H Handy, MD, Madison, 1981
Horace K Tenney, III, MD, Madison, 1981
Edward Zupanc, MD, Monroe, 1981

COMMITTEE ON SAFE TRANSPORTATION

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

Eugene Eckstam, MD, Monroe, 1979
Ralph F Hudson, MD, Eau Claire, 1979
Walter F Smejkal, MD, Manitowoc, 1979
Clarence E Moore, MD, Fond du Lac, 1980
James M Huffer, MD, Madison, 1980
Elmer E Johnson, MD, Madison, 1980
James L Weygandt, MD, Sheboygan Falls, 1981
Fred Bunkfeldt, Jr, MD, Milwaukee, 1981
Glenn C Hillery, MD, Lancaster, 1981

COMMITTEE ON FEDERAL LEGISLATION

of the Commission on Governmental Affairs

Robert F Purtell, Jr, MD, Milwaukee
Chairman
John Foreman, MD, Racine
Gerald C Kempthorne, MD, Spring Green
Robert Lotz, MD, Eau Claire
Robert Toohill, MD, Milwaukee
Raymond Zastrow, MD, Wauwatosa
Clarence Jordahl, MD, Milwaukee
David Weber, MD, Fond du Lac
Michael P Mehr, MD, Marshfield
Carl Eisenberg, MD, Milwaukee
Vice-chairman

Ex Officio:
Joseph M Lubitz, MD, Oconomowoc
Mr William Jackson, LaCrosse

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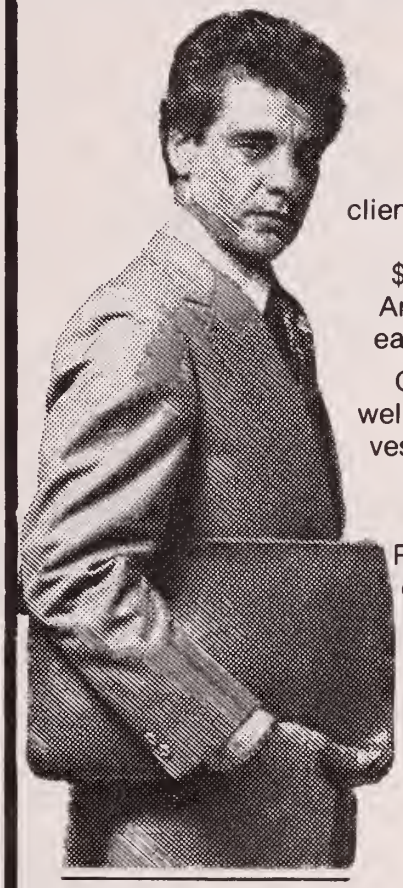

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COUNCIL COMMITTEES 1978-1979

EXECUTIVE COMMITTEE

Jules D Levin, MD, Milwaukee
President of the Society
Chairman
Darold A Treffert, MD, Winnebago
President-elect of the Society
Roy B Larsen, MD, Wausau
Immediate Past President
Paul S Haskins, MD, River Falls
Chairman of the Council
Timothy T Flaherty, MD, Neenah
Vice Chairman of the Council
John J Foley, MD, Menomonee Falls
Chairman, Finance Committee
Daniel K Schmidt, MD, Milwaukee
Chairman, Committee on Economic Medicine

ECONOMIC MEDICINE

Daniel K Schmidt, MD, Milwaukee
Chairman
Paul G LaBissoniere, MD, Wauwatosa
Russell F Lewis, MD, Marshfield
John P Mullooly, MD, Milwaukee
Timothy T Flaherty, MD, Neenah
William P Crowley, MD, Madison
Allen O Tuftee, MD, Beloit

FINANCE

John J Foley, MD, Menomonee Falls
Chairman
Richard W Edwards, MD, Richland Ctr
Walter F Smejkal, MD, Manitowoc
William A Nielsen, MD, West Bend
Blake E Waterhouse, MD, Madison
Wayne Boulanger, MD, Milwaukee
Joseph M Jauquet, MD, Ashland
Eugene J Nordby, MD, Madison
Treasurer, ex officio

NOMINATING

Paul S Haskins, MD, River Falls
Chairman of the Council
Chairman
Timothy T Flaherty, MD, Neenah
Vice-chairman of the Council
Jules D Levin, MD, Milwaukee
President
Darold A Treffert, MD, Winnebago
President-elect
Albert J Motzel Jr, MD, Waukesha
Speaker, House of Delegates

EVALUATION OF DELIVERY AND COST OF MEDICAL CARE

Blake E Waterhouse, MD, Madison
Chairman
Howard L Correll, MD, Arena
Gerald J Derus, MD, Madison
William P Crowley Jr, MD, Madison
Melvin F Huth, MD, Baraboo
George E Collentine Jr, MD, Milwaukee

AUXILIARY ADVISORY COMMITTEE

Mrs Charles R Lyons Sr, Oshkosh
President of the Auxiliary
Mrs Kenneth M Smigielski, Milwaukee
President-elect
Jules D Levin, MD, Milwaukee
President of the Society
Darold A Treffert, MD, Winnebago
President-elect
Roy B Larsen, MD, Wausau
Immediate Past President
Paul S Haskins, MD, River Falls
Chairman of the Council
Timothy T Flaherty, MD, Neenah
Vice-chairman
Earl R Thayer, Madison
Secretary ■

Are you wasting Disability dollars?

RECENT SURVEYS indicate that a majority of physicians carry adequate amounts of disability insurance. Unfortunately, some of these dollars are being wasted either as premiums are paid or as benefits are received. The reason—many physicians who are adequately insured for disability have no "Business Overhead Expense Insurance." As a consequence when disability strikes, a portion of the benefit paid must be used for continuing office expenses.

Let's define these two terms and also examine the differences between them. By so doing, the proper and most profitable usage of each will be clearly illustrated.

DEFINITIONS:

Disability income insurance:
Used to provide income for *personal* needs during a period of temporary or permanent disability.

Business overhead insurance:
Used to provide monies to pay ongoing practice operating expenses during a period of temporary disability (rent-heat-light-secretarial, etc).

DIFFERENCES:

Disability insurance

More expensive per dollar coverage.

If used for BOE, fewer dollars available for *personal* use.

Premiums *not* tax deductible for the individual.

Maximum deduction allowed on the Federal Tax of $5,000 per year, if total premium paid by individual.

Taxed as ordinary income if premiums paid by employer.

Business overhead expense insurance

Less expensive per dollar coverage.

No effect on dollars available for personal use. Premiums *are* tax deductible.

Benefits taxable, but as they are used to pay BOE they become fully tax deductible.

The above clearly illustrates the need to audit your insurance coverage ensuring that each of these valuable instruments is being used properly and to their greatest respective advantages. ■

County Medical Societies

Presidents, Secretaries and Meeting Schedules

County	*President*	*Secretary*	*Meeting*
Ashland—Bayfield—Iron	Charles R Longstreth, Rte. 1, Box 163 J, Ashland 54806	Howard N Sandin, 2101 Beaser Ave, Ashland 54806	On-call
Barron—Washburn—Brown	James A Rugowski, Rte 1, Box 146A, Cumberland 54829	Donald E Riemer, PO Box 127, Cumberland 54829	Second Tuesday of month
Brown	Harold J Hoops, 704 S Webster Ave, Green Bay 54301 *Treasurer:* Frederick J Lamont, 123 N Military Ave, Green Bay 54303	James R Mattson, 501 S Military Ave, Green Bay 54301 *Executive Secretary:* Ms Bernice Mangless, 501 S Military Ave, Green Bay 54301	Second Thursday of month
Calumet	Robert D Heinen, 26 School St, Chilton 53014	James C Pinney, 507-C West Main St, Hilbert 54129	On-call
Chippewa	Charles A Kemper, 727 Maple St, Chippewa Falls 54729	Gordon H Rosenbrook, 1518 Main St, Bloomer 54724	First Tuesday of month
Clark	Cahit H Ozturk, 216 Sunset, Neillsville 54456	Ana C Capati, RFD 3, Box 257 Neillsville 54456	On-call
Columbia—Marquette Adams	Charles D Grose, Rte 1, Portage 53901 *Executive Secretary:* Mrs Elayne Hanson, PO Box 352, 912 Cass St, Portage 53901	Fredrick H Bronson, RR 2, Fox Glen Rd, Portage 53901	On-call
Crawford	Thomas F Farrell, 610 E Taylor St, Prairie du Chien 53821	Michael S Garrity, 610 E Taylor St, Prairie du Chien 53821	On-call
Dane	R W Shropshire, 5001 Monona Dr Madison 53716	George F Roggensack, 1014 Hillside Ave, Madison 53705	First Tuesday of month
Dodge	Ki Jun Whang, 130 Warren St Beaver Dam 53916	Joseph Militello, 1200 N Center St, Beaver Dam 53916	Last Thursday of month
Door—Kewaunee	Jeffrey J Brook Jr, 108 So 10th Ave, Sturgeon Bay 54235		Fourth Tuesday of month, Sept thru May
Douglas	K G Ramesh, 3600 Tower Avenue, Superior 54880	Robert J Reibold, 7 Royalton Rd, Superior 54880	First Wednesday of month
Eau Claire—Dunn—Pepin	Jack D Edson, PO Box 224, Eau Claire 54701	J Randall Dennison, 733 W Claremont Ave, Eau Claire 54701	Fourth Monday of month
Fond du Lac	Clarence E Moore, 153 South Macy St, Fond du Lac 54935 *Treasurer:* David F Sweet, 80 Sheboygan St, Fond du Lac 54935	Jacob M Gerend, 827 Ellen Lane, Fond du Lac 54935	Fourth Thursday of month
Forest	E F Castaldo, Laona 54541	Burton S Rathert, 101 West Washington, Crandon 54520	On-call
Grant	Mildred Stone, 507 East Webster, Cuba City 53807	Harold W Carey, 257 Madison St, Lancaster 53813	On-call
Green	Carlos A Jaramillo, PO Box 596, Monroe 53566	Joseph J Dimartini, 1515-10th St, Monroe 53566	Third Monday of month, Feb, Apr, June, Aug & Nov
Green Lake—Waushara	David J Sievers, 270 E Marquette St, Berlin 54923	Enrique W Luy, Wild Rose 54984	On-call
Iowa	Young I Kim, 109 West Fountain St, Dodgeville 53533	Harald P Breier, 207 Main St, Montfort 53569	Second Tuesday of month, recess for summer
Jefferson	Manfred Effenhauser, PO Box 5, Lake Mills 53551	Poderoso G Prado, 218 Main St, Palmyra 53156	Third Thursday of month
Juneau	Clayton L Weston, 116 S Adams St, New Lisbon 53950	Jack Strong, 143 Division, Mauston 53948	On-call
Kenosha	Frederick Wood Jr, 6530 Sheridan Rd, Kenosha 53140 *Executive Secretary:* Mr Mark J Gorman, 3916-67th St, Kenosha 53140	A James Bennett, 3618 - 8th Ave, Kenosha 53140	First Thursday of month

continued next page

County	*President*	*Secretary*	*Meeting*
LaCrosse	Cornelius A Natoli, 2760 Hagen Rd, LaCrosse 54601	Stephen B Webster, 1836 South Ave, LaCrosse 54601	Third Monday of month
Lafayette			
Langlade	John E McKenna, 837 Clermont St, Antigo 54409		Second Tuesday of month
Lincoln	Jerome S Mayersak, 717 Tee Lane Dr, Merrill 54452	Muhammad Y Ahmad, 716 E Second St, Merrill 54452	Fourth Tuesday of month, Sept thru May
Manitowoc	Richard R Whereatt, 600 York, Manitowoc 54220	Edward J Barylak, 601 Reed Ave, PO Box 279, Manitowoc 54220	Last Tuesday of month
Marathon	Francis C Johnson, 2727 Plaza Dr, Wausau 54401	Bruce C Rhoades, 1100 Lakeview Dr, Wausau 54401	Last Monday of month
Marinette—Florence	Antoine Barrette, 132 North Emery St, Peshtigo 54157	James A Boren, 1510 Main St, Marinette 54143	Third Wednesday of month
Milwaukee	Shimpei Sakaguchi, 2040 W Wisconsin Ave, Milwaukee 53233 *Executive Director:* Mr Michael McManus, 411 E Mason St, Milwaukee 53202	Joseph L Teresi, 14760 Virginia Ave, Brookfield 53005	Dec (Annual), Feb, June & Oct
Monroe	Gustave A Landrum, PO Box 522, Tomah 54660	Jack D Brown, 202 South K St, Sparta 54656	Second Monday of month
Oconto		Forrest E Zantow, 415 Michigan Ave, Oconto 54153	Third Tuesday of month
Oneida—Vilas	Paul W Grotenhuis, Rte 5, Box 135, Rhinelander 54501	Leo G Norden, 1020 Kabel Ave, Rhinelander 54501	On-call
Outagamie	Joseph B Weissler, 610 E Longview Dr, Appleton 54911	Charles F Dungar, 506 E Longview Dr, Appleton 54911	Third Thursday of month
Ozaukee	Celestino M Perez, 326 W Pierre Lane, Port Washington 53704	Jaime D Cabatingan, W62N536 Washington Ave, Cedarburg 53012	Fourth Thursday of month
Pierce—St Croix	James R Beix, 409 Spruce St, River Falls 54022	John May, Baldwin 54002	Third Tuesday of month
Polk	Arnold S Potek, Osceola 54020	Herbert A Dasler, 127 Keller Ave, North, Amery 54001	Third Thursday of month
Portage	Clarence A Klasinski, 529 Division St, Stevens Point 54481	James D Miller, 950 College Ave, Stevens Point 54481	
Price—Taylor	Vladimir Uhri, 101 N Gibson Ave, Medford 54451	Walther W Meyer, 101 N Gibson Ave, Medford 54451	Quarterly
Racine	Dennis J Kontra, 5814 Washington Ave, Racine 53406 *Treasurer:* Victoriano A Baylon, 717-15th St, Racine 53403	Huron L Ericson, 12 Raven Turn, Racine 53402 *Executive Secretary:* Mr Gilbert J Berthelsen, PO Box 592, Racine 53403	Third Thursday of month
Richland	Gerald R Wisniewski, 1289 W Seminary St, Richland Center 53581	L M Pippin, 1313 W Seminary St, Richland Center 53581	First Thursday of month
Rock	Paul F Frechette, 100 E Milwaukee St, Janesville 53545	Thomas M Shearer, 1011 N Main St, Edgerton 53534	On-call
Rusk	Ralph P Bennett, 906 W College Ave, Ladysmith 54848	Joseph E Murphy, 403 E Miner Ave, Ladysmith 54848	Third Tuesday of month
Sauk	David P Kuter, 703 - 14th St, Baraboo 53913	Donald W Vangor, 703 - 14th St, Baraboo 53913	Second Tuesday of month, Sept thru May
Sawyer	Lloyd M Baertsch, Rte 6, Box 700, Hayward 54843	Paul Strapon III, Rte 6, PO Box 700, Hayward 54843	
Shawano	R David Petty, 117 E Green Bay St, Shawano 54166	A J Sebesta, 126½ S Main St, PO Box 311, Shawano 54166	Fourth Monday of month

County	President	Secretary	Meeting
Sheboygan	Thomas Mockert Jr, 1720 N 8th St, Sheboygan 53081	Donald D Ohme, 1011 N 8th St, Sheboygan 53081	Third Thursday of month
Trempealeau—Jackson Buffalo	Gary K Peterson, 610 W Adams St, Black River Falls 54615	James J Dickman II, 610 W Adams St, Black River Falls 54615	Fourth Tuesday of month
Vernon	P T Bland, 100 Melby St, Westby 54667	DeVerne W Vig, 125 W Jefferson Viroqua 54665	On-call
Walworth	Daniel R Hansen, Rte 1, Walworth 53181	Menandro Tavera Jr, Rte 4, Box 126, Lake Geneva 53147	Third Thursday of month
Washington	William J Listwan, PO Box 178, West Bend 53095	James F Baumgartner, PO Box 178, West Bend 53095	Fourth Thursday of month, except July, Aug & Dec
Waukesha	LaVern H Herman, 1200 Sweetbriar Dr, Waukesha 53186 *Treasurer:* Matthew A Meyer, 217 Wisconsin Ave, Waukesha 53186	Michael McCormick, 102 East Main St, Waukesha 53186 *Executive Secretary:* Mr Robert Herzog, 850 Elm Grove Rd, Elm Grove 53122	First Wednesday of month
Waupaca	Terry L Hankey, 710 Riverside Dr, Waupaca 54981	Jerry R Salan, 710 Riverside Dr, Waupaca 54981	Second or Third Thursday of month
Winnebago	James L Basiliere, 515 Doctors Ct, Oshkosh 54901	George W Arndt, 706 East Forest Ave, Neenah 54956	First Thursday of month, except July & Aug
Wood	Jung Kyun Park, 410 Dewey St, Wisconsin Rapids 54494	Homer Russ, 1000 North Oak Ave, Marshfield 54449	On-call

All officers above are MDs unless Mr or Mrs is indicated.

OFFICERS OF SPECIALTY SECTIONS OF THE STATE MEDICAL SOCIETY

A listing of the officers of Specialty Sections of SMS was not available at the time of this printing, and therefore will appear in a future issue.

CME requirements for licensure in Wisconsin

Currently 45 hours of continuing medical education are required for the three-year period: January 1, 1977 through December 31, 1979, as a condition of licensure for the period: January 1, 1980 through December 31, 1981. This means that proof of attendance at and completion of at least 45 hours of acceptable CME programs must be submitted to the State Medical Examining Board in the third year (1979) at the time of making application for a certificate of registration for the next period: January 1, 1980 through December 31, 1981.

During the 1977 legislative session, the above requirements were changed, effective with the licensure period: January 1, 1982 through December 31, 1983. (This change does not affect the licensure period: January 1, 1980 through December 31, 1981.) The new law requires 30 hours of CME during a two-year period (calendar years 1980-1981) preceding the period of licensure; *ie,* proof of attendance at and completion of at least 30 hours of acceptable CME programs must be submitted to the State Medical Examining Board in the second year (1981) at the time of making application for a certificate of registration for the licensure period: January 1, 1982 through December 31, 1983.

The change from a three-year period to a two-year period for certifying CME credits was made to coincide with the new two-year term of licensure, starting with the licensure period: January 1, 1978 through December 31, 1979.

Physicians are urged to accumulate the credit hours until the total hours required can be submitted to the Medical Examining Board in one document prior to the next registration period.

STATE MEDICAL SOCIETY OF WISCONSIN AUXILIARY
Officers and Directors for 1978-1979

ELECTED OFFICERS

President: Mrs Charles R Lyons, Sr., 2000 East Murdock Ave, Oshkosh 54901
President-elect: Mrs Kenneth Smigielski, 3351 West Poe St, Milwaukee 53215
Vice President: Mrs Glenn M Seager, Route 1, Carla Court, Stoddard 54658
Recording Secretary: Mrs Duane Taebel, 2290 Wedgewood Drive, East, LaCrosse 54601
Treasurer: Mrs Charles Yale, 209 Farwell Drive, Madison 53704
Immediate Past President: Mrs John E Mielke, 11 Reid Court, Appleton 54911

DIRECTORS

East-Central: Mrs David R Weber, 149 Cottage Ave, Fond du Lac 54935
West-Central: Mrs Carl W Manz, 4442 Meadow Lane, Eau Claire 54701
Northeast: Mrs Daniel W Shea, 1336 Ridgeway Boulevard, De Pere 54115
Northwest: Mrs Joseph M Jauquet, 1201 Vaughn Avenue, Ashland 54806
Southeast: Mrs Irwin Bruhn, Route 1, Lakeville Road, Walworth 53184
Southwest: Mrs Sigurd E Sivertson, 305 Blue Ridge Parkway, Madison 53705

APPOINTED OFFICERS

Parliamentarian: Mrs Hobart Wright, 8026 West Wisconsin Ave, Milwaukee 53213
Historian: Mrs Robert C Baldwin, 119 Concord Ave, Watertown 53094

EXECUTIVE SECRETARY

Mrs LaVerne Bartel, 330 East Lakeside St, Madison 53715 ■

JCAH issues new standards for medical staffs

On February 1, 1978 the Joint Commission on Accreditation of Hospitals' *Revised Standards for Medical Staffs* went into effect. Dr. John E Affeldt, the president of the Joint Commission, had the following outlook on the Standards: "We're saying to doctors, 'To ensure good patient care, these standards should be followed. They'll help you evaluate your own practices, skills, knowledge, and outcomes—and you'll do that within your own staff." The most significant changes for doctors will be:

- STAFF MEMBERSHIP—*Qualification*—Beyond requiring a medical license and formal application, the old standard set few specific requirements for staff membership and clinical privileges. Now medical staffs will have to take a harder and more detailed look at the applicant's credentials.

- STAFF MEMBERSHIP—*Delineation of Privileges*—After years of holding simply that there will be privilege delineation for medical staff members, the Commission found that this provision was getting more lip service than anything else. The new standard is meant to assure that the right staff member is doing the right things to the patient. So specialty designation such as "general surgery" or "family practice" will no longer be enough.

- STAFF MEMBERSHIP—*Reappointment*—For the first time in the Standards, a doctor's health will be one of the factors that must be weighed in considering his reappointment.

- STAFF ORGANIZATION—Every staff doctor's responsibility should be spelled out in the bylaws, whether he's a courtesy member who admits maybe 12 patients a year or an active staff member who fills half the beds on a service.

- STAFF REGULATIONS—Provisions about medical staff bylaws, rules, and regulations remain essentially the same as before, but with a "clarification" of the requirement that bylaws establish fair hearing and appeal mechanisms in connection with denial of appointment or reappointment, as well as curtailment, suspension, or revocation of privileges.

- STAFF MONITORING—A sign of the times is this new standard requiring that patient care be evaluated on a regular basis through utilization review, audits, and other mechanisms established by the medical staff. Quality controls will include not only tissue review but reviews of pharmacy and therapeutic activities, blood utilization, clinical use of antibiotics, and other patient-related professional activities.

- STAFF EDUCATION—The old continuing education requirements were brief and vague; they've been expanded and made more specific. The Standards require a hospital-sponsored program designed both for refresher work and for introducing new diagnostic and therapeutic techniques. The Standards also specify that in small, nondepartmentalized hospitals, the continuing education sessions cannot be less than quarterly, although they may be tied in with medical staff meetings.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Council and Officers of the State Medical Society and up to ten elected non-medical persons. In addition each of the 54 component county societies may elect a representative who is considered a corporate member of the Board. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

OFFICERS

PRESIDENT: R T Cooney MD, Portage—1978

VICE-PRESIDENT: R M Senty MD, Sheboygan—1978

TREASURER: L C Pomainville MD, Wisconsin Rapids—1978

SECRETARY: Mr E R Thayer, Madison—1978

BOARD OF TRUSTEES

OFFICERS AND COUNCILORS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

J D Levin MD, Milwaukee—1979
D A Treffert MD, Winnebago—1979
R B Larsen MD, Wausau—1979
Mr E R Thayer, Madison—1979
E J Nordby MD, Madison—1979
A J Motzel Jr MD, Waukesha—1979
D W Taebel MD, LaCrosse—1979
P S Haskins MD, River Falls—1980
R W Edwards MD, Richland Center—1979
C SL Eisenberg MD, Milwaukee—1980
W J Boulanger MD, Milwaukee—1981
D K Schmidt MD, Milwaukee—1981
J J Foley MD, Menomonee Falls—1981
E A Steffen MD, Racine—1981
W A Nielsen MD, West Bend—1981
I J Bruhn MD, Walworth—1981
P G LaBissoniere MD, Wauwatosa—1979
J P Mullooly MD, Milwaukee—1979
W P Crowley MD, Madison—1981
A O Tuftee MD, Beloit—1979
B E Waterhouse MD, Madison—1979
C A Natoli MD, LaCrosse—1980
J J Kief MD, Rhinelander—1980
R F Lewis MD, Marshfield—1980
J U Peters MD, Fond du Lac—1979
T T Flaherty MD, Neenah—1980
Antoine Barrette MD, Peshtigo—1980
W F Smejkal MD, Manitowoc—1979
J M Jauquet MD, Ashland—1981

NON-MEDICAL TRUSTEES

Mr George Kress, Green Bay—1980
Mr Robert B Murphy, Madison—1980
Mr George Becker, Fond du Lac—1978
Mr Donald S DeWitt, Oconto—1978
Mrs Audrey Baird, Wauwatosa—1979
Mrs Nancy McDowell, Milwaukee—1979
Mrs Catherine McCormick, Shawano—1979
The Honorable Kent C Houck, Richland Center—1981
Mrs Janet Hartzell, Grantsburg—1980

CORPORATE MEMBERS REPRESENTING COMPONENT COUNTY MEDICAL SOCIETIES

A A Koeller MD (Ashland-Bayfield-Iron)—1980
Vacancy (Barron-Washburn-Burnett)—1979
R L Troup MD (Brown)—1980
J L Jaeck MD (Calumet)—1979
J J Sazama MD (Chippewa)—1979
K F Manz (Clark)—1981
R T Cooney MD (Columbia-Marquette-Adams)—1980
E M Dessloch MD (Crawford)—1980
A P Schoenenberger MD (Dane)—1980
Vacancy (Dodge)—1978
R G Evenson MD (Door-Kewaunee)—1980
Milton Finn MD (Douglas)—1980
G E Wahl MD (Eau Claire-Dunn-Pepin)—1979
J S Huebner MD (Fond du Lac)—1980
B S Rathert MD (Forest)—1981
C L Steidinger MD (Grant)—1980
Vacancy (Green)—1980
D J Sievers MD (Green Lake-Waushara)—1981
H P Breier MD (Iowa)—1980
J S Garman MD (Jefferson)—1981
R F Farne MD (Juneau)—1981
H P Rafferty MD (Kenosha)—1979
L J Logan MD, (LaCrosse)—1981
Vacancy (Lafayette)—1980
E J Roth MD (Langlade)—1979
J F Bigalow MD (Lincoln)—1981
J R Larsen MD (Manitowoc)—1979
J G Sack MD, (Marathon)—1981
C E Koepp MD (Marinette-Florence)—1980
J D Levin MD (Milwaukee)—1980
G A Landmann MD (Monroe)—1981
J S Honish MD (Oconto)—1980
Marvin Wright MD (Oneida-Vilas)—1979
G W Carlson MD (Outagamie)—1980
R F Henkle MD (Ozaukee)—1979
C A Olson MD (Pierce-St Croix)—1979
John O Simenstad, MD (Polk)—1979
W C Sheehan MD (Portage)—1981
W W Meyer MD (Price-Taylor)—1979
C E Oberdorfer MD (Racine)—1979
R W Edwards MD (Richland)—1980
J J Tordoff MD (Rock)—1980
William Bauer MD (Rusk)—1979
H P Baker MD (Sauk)—1980
Vacancy (Sawyer)—1979
J J Albright MD (Shawano)—1980
R M Senty MD (Sheboygan)—1979
C F Meyer MD (Trempealeau-Jackson-Buffalo)—1981
R A Starr MD (Vernon)—1981
J A Rawlins MD (Walworth)—1979
R G Edwards MD (Washington)—1979
W D James MD (Waukesha)—1981
J H Steiner MD (Waupaca)—1981
George W Arndt, MD (Winnebago)—1980
L C Pomainville MD (Wood)—1981

Recipients of Awards Presented by the State Medical Society of Wisconsin

COUNCIL AWARD

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

(Recipients from 1930-1971 were listed in the January 1973 Blue Book issue; subsequent recipients in the 1975 BB issue).

Eli M Dessloch, MD, Prairie du Chien 1977
Ben R Lawton, MD, Marshfield 1978

CIVIC LEADERSHIP AWARD

Established by the Council in 1972, the Civic Leadership Award recognizes a member of the State Medical Society of Wisconsin for his outstanding contributions in the activities of his community and the medical society.

(Recipients from 1972-1976 were listed in the June 1976 Blue Book issue.)

Paul B Mason, MD, Sheboygan 1978

HOUGHTON MEDICAL STUDENT AWARD

Granted annually to a student from each of Wisconsin's two medical schools who, through scholastic excellence, extracurricular achievement, and interest in medical organization, show high promise of becoming a complete physician. Established by MDs John H and William J Houghton, brothers, who were councilors of the State Medical Society of Wisconsin; John H also was president. Established in 1968 through funds contributed to the Society's Charitable, Educational and Scientific Foundation.

(Recipients from 1968-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

Richard Immler (University of Wisconsin Medical School) 1978
Margaret Chen (Medical College of Wisconsin) 1978

ELVEHJEM MEMORIAL LECTURE AWARD

Established in 1962 by the Council to honor the memory of Conrad A Elvehjem, PhD, the thirteenth president of the University of Wisconsin and an international authority in biochemistry. It is presented through auspices of the Society's Charitable, Educational and Scientific Foundation and is designed to perpetuate Doctor Elvehjem's contribution to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians. Lecturers are selected by the Commission on Continuing Medical Education (formerly Commission on Scientific Medicine) for participation in the Annual Meeting scientific program.

(Recipients from 1963-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

Kevin Parent, MD, Marshfield 1978

BEAUMONT MEMORIAL LECTURE AWARD

Established in 1957 by the Council to memorialize one of Wisconsin's early frontier surgeons. Sponsored by the Society's Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. Lecturers are selected by the Commission on Continuing Medical Education (formerly Commission on Scientific Medicine) for participation in the Annual Meeting scientific program.

(Recipients from 1958-1972 were listed in the January 1973 Blue Book issue; subsequent recipients each year starting with the 1974 BB issue)

David B Skinner, MD, Chicago, Ill 1978

FIFTY YEAR CLUB AWARDS

Annually the State Medical Society of Wisconsin pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity.

1978

Raymond M Baldwin, MD .....Beloit
Sylvester E Coffey, MD .....Wauwatosa
Conde F Conroy, MD .....Milwaukee
Harold E Cook, MD .....Wind Lake
R W Farnsworth, MD .....Janesville
Hubert J Farrell, MD .....Milwaukee
William W Ford, MD .....Green Bay
Joseph J Grimm, MD .....South Milwaukee
Maurice A Hardgrove, MD .....Milwaukee
John B Hitz, MD .....Nashotah
Francis J Huberty, MD .....Appleton
Francis L Hummer, MD .....Sun City, AZ
George H Jurgens, MD .....Wauwatosa
James J King, MD .....Milwaukee
William H Lipman, MD .....San Diego, CA
Walton R Manz, MD .....Eau Claire
Robert P Montgomery, MD .....Milwaukee
Harold H Oberfeld, MD .....Milwaukee
Alphonsus M Rauch, MD .....Lake Geneva
Raymond R Richards, MD .....Eau Claire
Otto E Rydell, MD .....Rice Lake
Albert G Schutte, MD .....Mukwonago
John D Wilkinson, MD .....Oconomowoc

PHYSICIANS NOT EXEMPT FROM JURY DUTY

Recent state legislation (AB 1075) has been signed into law by the Governor that no longer exempts physicians from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused. Physicians interested in further details may contact the SMS Physicians Alliance Division: toll-free 1-800-362-9080.

PRESIDENTS AND SECRETARIES, WISCONSIN SPECIALTY SOCIETIES

WISCONSIN ALLERGY SOCIETY
President—Raymond L Hansen, MD (Sept 1979), 1000 N Oak Ave, Marshfield 54449
Secretary—William Busse, MD (Sept 1979), 504 N Walnut St, Madison 53706

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS
President—Richard A Manhart, MD (Sept 1978), Rt #2, Maurer Rd, Cross Plains, 53528
Secretary—W Stuart Sykes, MD (Sept 1978), 1005 Columbia Rd, Madison 53705

WISCONSIN DERMATOLOGICAL SOCIETY
President—Sharon D H Lantis, MD (Nov 1978), 1552 University Ave, Madison 53706
Secretary—Eugene Monroe, MD (Nov 1979), 9490 N Waverly Dr, Milwaukee 53217

WISCONSIN ACADEMY OF FAMILY PHYSICIANS
President—James N Moore, MD (July 1979), 5714 Odana Rd, Madison 53719
Secretary—John O Grade, MD (July 1979), 1050 Legion Dr, Elm Grove 53122

WISCONSIN SOCIETY OF INTERNAL MEDICINE
President—Michael Mehr, MD (Sept 1978), 1000 N Oak Ave, Marshfield 54449
Secretary—Michael Mally, MD (Sept 1978), 1004 E Sumner St, Hartford 53027

WISCONSIN NEUROLOGICAL SOCIETY
President—Paul G Gottschalk, MD (May 1979), 1000 N Oak Ave, Marshfield 54449
Secretary—Raymond Chun, MD (May 1979), 1300 University Ave, Madison 53706

WISCONSIN NEUROSURGICAL SOCIETY
President—Allan B Levin, MD (Oct 1978), 1300 University Ave, Madison 53706
Secretary—Teofilo O Odulio, MD (Oct. 1978), 2801 N 7th St, Wausau 54401

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY
President—C Weir Horswill, MD (July 1979), 2630 Amherst Rd, Middleton 53562
Secretary—Michael Stevens, MD (July 1979), 1000 N Oak Ave, Marshfield 54449

WISCONSIN ORTHOPAEDIC SOCIETY
President—Paul Odland, MD (Apr 1979), 510 N Terr, Janesville 53545
Secretary—Gerald P Gredler, MD (Apr 1979), 510 N Terr, Janesville 53545

WISCONSIN OTOLARYNGOLOGICAL SOCIETY
President—Jerry E Friedman, MD (Apr 1979), 2040 W Wisconsin Ave, Milwaukee 53233
Secretary—Charles H Mann, MD (Apr 1979), 1605 Monroe St, Madison 53711

WISCONSIN SOCIETY OF PATHOLOGISTS
President—J M B Bloodworth, Jr, MD (Mar 1979), 2500 Overlook Terr, Madison 53705
Secretary—Charles P Nichols, MD (Mar 1979), 709 S 10th, LaCrosse 54601

WISCONSIN CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
President—Rolv K Slungaard, MD (May 1979), 1836 South Ave, LaCrosse 54601
Secretary—William S Freeman, MD (May 1979), 1146 Grant, Beloit 53511

WISCONSIN PSYCHIATRIC ASSOCIATION
President—Robert F Goerke, MD (Apr 1979), 811 E Wisconsin Ave, Milwaukee 53202
Secretary—George Arndt, MD (Apr 1979), 706 E Forest Ave, Neenah 54956

WISCONSIN SOCIETY OF PHYSICAL MEDICINE & REHABILITATION
President—Salvatore A Spicuzza, MD (Mar 1979), 1820 Melody Lane, Brookfield 53005
Secretary—Basilio Lopez, MD (Mar 1979), 3321 N Maryland, Milwaukee 53211

WISCONSIN SOCIETY OF PLASTIC SURGEONS
President—Sidney K Wynn, MD (Apr 1979), 606 W Wisconsin Ave, Milwaukee 53203
Secretary—Jerome J Luy, MD (Apr 1979), 425 E Wisconsin Ave, Milwaukee 53202

WISCONSIN SOCIETY FOR PREVENTIVE MEDICINE
President—Richard Biek, MD (Apr 1979), 1029 N Jackson St, Milwaukee 53202
Secretary—George Handy, MD (Apr 1979) 5910 Mineral Pt Rd, Madison 53705

WISCONSIN SOCIETY OF RADIATION ONCOLOGISTS
President—Maurice Greenberg, MD (Sept 1979), 8700 W Wisconsin Ave, Milwaukee 53226
Secretary—Marcia Richards, MD (Sept 1979), 2315 N Lake Dr, Milwaukee 53211

WISCONSIN RADIOLOGICAL SOCIETY
President—Donald P Babbitt, MD (Sept 1979), 1700 W Wisconsin Ave, Milwaukee 53233
Secretary—Daniel J Price, MD (Sept 1979), 2400 W Villard Ave, Milwaukee 53209

WISCONSIN SURGICAL SOCIETY
President—Edward Bachhuber, MD (Apr 1979), 8700 W Wisconsin Ave, Milwaukee 53226
Secretary—Raymond Watson, MD (Apr 1979), 2266 N Prospect, Milwaukee 53202

WISCONSIN UROLOGICAL SOCIETY
President—John D Silbar, MD (Apr 1979), 2040 W Wisconsin Ave, Milwaukee 53233
Secretary—Raul F Waters, MD (Apr 1979), 1313 Fish Hatchery Rd, Madison 53715 ■

THE FOUNDATION FOR MEDICAL CARE EVALUATION OF SOUTHEASTERN WISCONSIN, INC

BOARD OF CONTROL

KENNETH O JOHNSON, MD, *President*, 3003 W Goodhope Rd, Milwaukee 53209

PHILIP TAUGHER, MD, *Vice President*, 2400 S 90th St, West Allis 53227

DAVID N GOLDSTEIN, MD, *Secretary*, Box 743, Kenosha 53141

MARK C KISELOW, MD, *Treasurer*, 1626 N Prospect Ave, Milwaukee 53202

VINCENT BANKER, MD, 7310 Wellauer Dr, Milwaukee 53213

ADDIS COSTELLO, MD, 811 E Wisconsin Ave, Milwaukee 53202

EUGENE COX, 10427 Watertown Plank Rd, Milwaukee 53225

CHESLEY P ERWIN, MD, 8700 West Wisconsin Ave, Milwaukee 53226

ROCCO S GALGANO, MD, 610 Walworth Ave, Delavan 53115

LEO R GRINNEY, MD, 3803 Spring St, Racine 53405

THOMAS F JENNINGS, MD, 2400 S 90th St, West Allis 53227

KENNETH J KURT, DO, 15300 Watertown Plank Rd, Elm Grove 53122

CRAIG LARSON, MD, 811 East Wisconsin Ave, Milwaukee 53202

JULES D LEVIN, MD, 1530 West Spruce Court, Milwaukee 53217

MICHAEL J MALLY, MD, 1004 East Sumner St, Hartford 53027

NICHOLAS L OWEN, MD, 425 East Wisconsin Ave, Milwaukee 53202

ROBERT F PURTELL, JR, MD, 3316 West Wisconsin Ave, Milwaukee 53208

DOLORES SPANGLER, 918 North Fourth St, Milwaukee 53203

MARVIN WAGNER, MD, 2300 North Mayfair Rd, Milwaukee 53226

THOMAS WALL, MD, 9209 West Hawthorne Ave, Mequon 53092

KARL YORK, 1320 Wisconsin Ave, Racine 53403 ■

WISCONSIN PROFESSIONAL REVIEW ORGANIZATION (WisPRO)

BOARD OF CONTROL

*JOHN K SCOTT, MD, *Chairman*, 1605 Monroe St. Madison 53711

*JOHN J KIEF, MD, *Vice-chairman*, 1020 Kabel Ave, Rhinelander 54501

*ANCIL I FREIBURGHOUSE, DO, *Secretary*, 721 W Madison, Lake Mills 53551

†*ROBERT E CULLEN, MD, *Treasurer*, 527 East Division St, Fond du Lac, 54935

GEORGE R BARRY, MD, 1515 - 10th St, Monroe 53566

JOYCE CONNOLLY, RN, 401 West Grand Ave, Chippewa Falls 54729

JAMES L ESSWEIN, MD, 85 Chichester, Chetek 54728

H D GREEN, DDS, 419 Pleasant St, Beloit 53511

PAUL S HASKINS, MD, 409 Spruce St, River Falls 54022

MELVIN F HUTH, MD, 203 Fourth St, Baraboo 53913

SIDNEY E JOHNSON, MD, 1000 N Oak Ave, Marshfield 54449

*MARSHALL F PURDY, MD, 23 West Milwaukee St, Janesville 53545

†WELDON D SHELP, MD, 309 W Washington Ave, Madison 53703

†WALTER F SMEJKAL, MD, PO Box 279, Manitowoc 54220

DUANE W TAEBEL, MD, 1836 South Ave, LaCrosse 54601

*PHILIP H UTZ, MD, 709 South 10th St, LaCrosse 54601

*KENNETH VAN BREE, Admin, Divine Savior Hospital, 1015 W Pleasant St, Portage 53901

DONALD J MCINTYRE, *Executive Director*, PO Box 1109, Madison 53701

*Executive Committee

†Finance Committee

WisPRO DISTRICT REVIEW COUNCILS

Northwest District Review Council

THOMAS J DOYLE, SR, MD, 1507 Tower Ave, Superior 54880

JAMES L ESSWEIN, MD, 85 Chichester, Chetek 54728

HARRY CONLAG, MD, 733 West Clairemont, Eau Claire 54701

KENNETH W HALGRIMSON, MD, 2712 Stein Blvd, Box 224, Eau Claire 54701

ROLAND M HAMMER, MD, 409 Spruce St, River Falls 54022

PHILIP J HAPPE, MD, 823 Bradley Ave, Eau Claire 54701

HARRY H LARSON, MD, 1321 Sixth Ave, West, Ashland 54806

STANLEY G NORMAN, MD, 2119 Heights Dr, Eau Claire 54701

LESTER J OLSON, MD, 222 Oak St, Spooner 54801

BRUNO F RAHN, MD, RR #6, Box 162, Chippewa Falls 54729

FRED B RIEGEL, MD, 208 Adams St, South, St Croix Falls 54024

CARROLL D RUND, MD, 2211 Stout Rd, Menomonie 54751

HARRY SILVERNALE, *District Manager*, PO Box 1109, Madison 53701

North Central District Review Council

SAMIR L ABADEER, MD, 400 E Thomas St, Wausau 54401

BOYD GROTH, MD, 607 13th St, Mosinee 54455

BAHRI O GUNGOR, MD, 216 Sunset Pl, Neillsville 54456

RAYMOND L HANSEN, MD, 1000 North Oak, Marshfield 54449

CHARLES A HEUSS, MD, 1111 Langlade, Antigo 54409

ARTHUR J JACOBSEN, MD, Lakeland Associates Ltd, Woodruff 54568

JAMES R KEUER, MD, 101 North Gibson Ave, Medford 54451

JOHN J KIEF, MD, 1020 Kabel Ave, Rhinelander 54501

MICHAEL K MIKKELSON, MD, 800 Riverside Ave, Merrill 54452

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SIGURD B GUNDERSEN, JR, MD, 1836 South Ave, LaCrosse 54601

EDWARD B MINER, MD, 1836 South Ave, LaCrosse 54601

JOHN J SATORY, MD, 1404 Main St, LaCrosse 54601

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PHILIP H UTZ, MD, 709 South 10th St, LaCrosse 54601

WILLIAM E WRIGHT, MD, 250 Buffalo St, Mondovi 54755

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JOHN E KRAUS, MD, 1510 Main St, Marinette 54143

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DAVID E PAPENDICK, MD, 801 Fourth St, Algoma 54201

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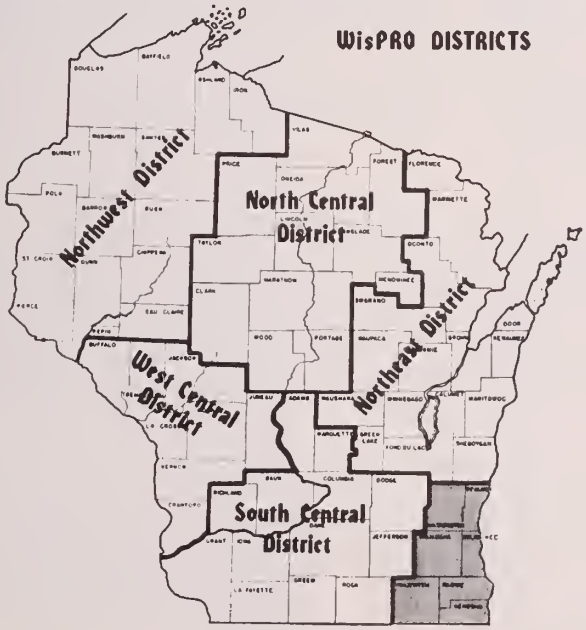
THOMAS J THOMAS, MD, 117 East Green Bay St, Shawano 54166

THOMAS D HANSTROM, *District Manager,* 2711 Regina St, Green Bay 54301 ■



HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be mentally retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

- CHILD DEVELOPMENT CENTER

  Dr June Dobbs, Director
  Milwaukee Children's Hospital
  1700 West Wisconsin Ave
  Milwaukee, Wisconsin
  (414) 344-7100

- UNIVERSITY HOSPITALS

  Dr Charles Schoenwetter
  1552 University Ave
  Madison, Wisconsin 53706
  (608) 262-9983

- WAISMAN CENTER ON MENTAL RETARDATION

  Linne Cain, Intake Coordinator
  1500 Highland Ave
  Madison, Wisconsin 53706
  (608) 263-5776

- COMPREHENSIVE EVALUATION CLINIC FOR MULTIPLI-HANDICAPPED CHILDREN

  Ms Marilyn Gratto
  Miller-Dwan Hospital
  502 East 2nd Street
  Duluth, Minnesota 55805

Further information may be obtained from Rosemarie Reed, Information and Referral Outreach, Wisconsin Association for Retarded Citizens, Inc, 2700 Laura Lane, Middleton, Wis 53562; (608) 831-3444.

SPECIAL TO THE JOURNAL

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee (Medical College of Wisconsin Medical Library). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Midwest Health Science Library Network, which encompasses a six-state area, to the National Library of Medicine; and, if necessary, to the British Lending Library.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computerized MEDLINE searches can now be done at the resource libraries and at the Luther Hospital, Eau Claire; LaCrosse Lutheran Hospital; the Howard Young Medical Center, Woodruff; and St Mary's Hospital in Madison. If your local library cannot provide MEDLINE, it can forward any request to the most appropriate library in the network.

In most cases, the only charge will be for MEDLINE searches (generally $4.00) and for photocopies.

Medical Library Service
University of Wisconsin
Middleton Health Sciences
Library
1305 Linden Drive
Madison, Wisconsin 53706

Medical College of Wisconsin
Medical Library
560 North 16th Street
Milwaukee, Wisconsin 53233

■

Brief Summary of Prescribing Information
Combined TEGOPEN® (cloxacillin sodium)
Capsules and Oral Solution
For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75

Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

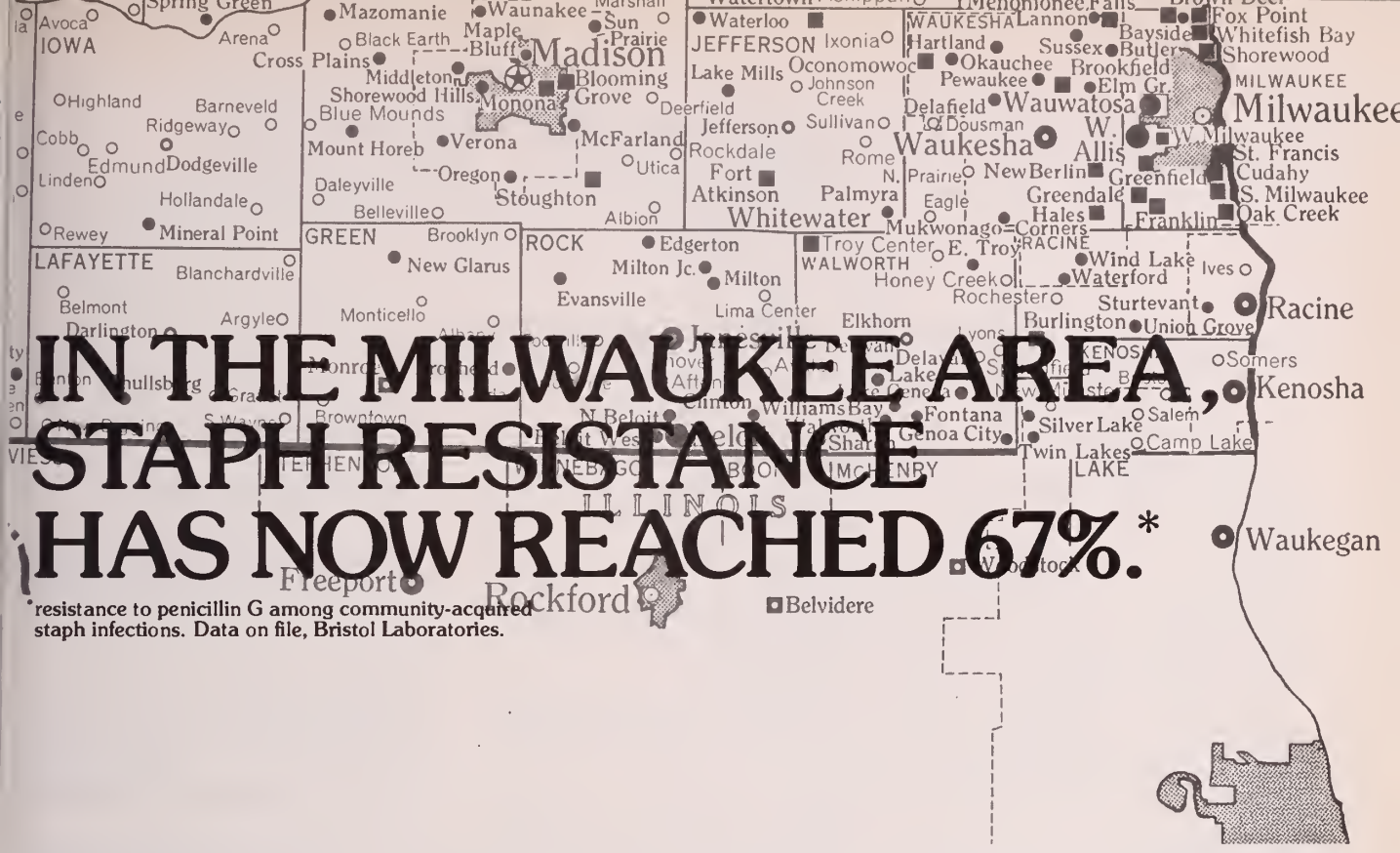
Usual Dosage: Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

Supplied: Capsules—250 mg. in bottles of 100, 500 mg. in bottles of 100. Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



IN THE MILWAUKEE AREA, STAPH RESISTANCE HAS NOW REACHED 67%.*

*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

WHEN YOU CAN'T RULE OUT STAPH, CONSIDER

TEGOPEN®
(cloxacillin sodium)

..."THE PENICILLIN OF TODAY"

- Effective against nonpenicillinase-producing staphylococci, beta-hemolytic streptococci, and pneumococci.†

†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

- 10 times more active against strep than staph.
- Well absorbed from the G.I. tract.‡

‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.

Please see brief summary for prescribing information.

STATE GOVERNMENT AGENCIES

A VALUABLE REFERENCE FOR PRACTICING PHYSICIANS AND ALLIED HEALTH PERSONNEL

Department of Health and Social Services

1 W Wilson St, Madison, Wis 53702
Tel 608/266-3681

EXECUTIVE STAFF

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Donald Percy 266-3681

DEPUTY SECRETARY
Terry Willkom 266-3681

DIVISION ADMINISTRATORS
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Policy and Budget

Nate Harris 266-3173
Management Services

Allyn R Sielaff 266-2471
Corrections

Bernard Stumbras 266-3416
Economic Assistance

Robert Durkin 266-1511
Health

Leonard J Ganser, MD 266-2701
Community Services

Terry Willkom 266-1281
Vocational Rehabilitation

DIVISION OF HEALTH

1 W Wilson St; Room 434
PO Box 309
Madison, Wis 53701
Tel 608/266-1511

Note: Use box number on First Class Mail

ADMINISTRATOR
Robert Durkin

DEPUTY ADMINISTRATOR
Vacancy

OFFICE OF OPERATIONS AND MANAGEMENT
Lloyd Riddle

OFFICE OF HEALTH ECONOMICS

BUREAUS

Planning **266-7295**
- Staffing of Health Policy Council and its committees
- Development of State Health Plan
- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan
- Development of emergency medical services systems

Needs Review **266-7384**
- Review of 1122 capital expenditures
- Certificate of Need
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal

Health Care Financing Control **266-2522**
- Oversight of the hospital and rate review process
- Administration of the Medical Assistance Program
- Promotion of plans for prepayment of comprehensive health services
- Liaison with Office of the Insurance Commissioner

Quality Compliance **266-8847**
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards
- Laboratory certification

Prevention **266-1251**
- Development and promotion of prevention programs
- Standard epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Health education

Community Health **266-2661**
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning
- Early and periodic screening, diagnosis and treatment (EPSDT) for children and other screening activities

Institutional Health Services .**266-5718**
- Assurance of sufficient levels of physical health care for all inmates in correctional institutions and at Central State Hospital
- Management of the provision of such services to insure effectiveness and efficiency
- Recruitment and staffing of health care positions in the institutions

Environmental Health **266-1704**
- Certification of Grade A milk
- Platting of unsewered subdivisions
- Septic tank regulation
- Plumbing and fire protection services
- Inspection of hotels, restaurants and food vending services where not performed by local public health agencies
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services

Health Statistics **266-1939**
- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

REGIONAL OFFICES
Division of Health

No 1—MADISON 53719
5712 Odana Road
Tel 608/266-2245

No 2—MILWAUKEE 53216
6815 W Capitol Dr
Tel 414/466-9763

No 3—FOND DU LAC 54935
485 S Military Rd; PO Box 269
Tel 414/922-1290

No 4—GREEN BAY 54303
1181 Western Ave; PO Box 3860
Tel 414/497-3219

No 5—LACROSSE 54601
District State Office Building
3550 Mormon Coulee Rd
Tel 608/785-9431

No 6—EAU CLAIRE 54701
District State Office Building
718 W Clairemont Ave
Tel 715/836-5362

No 7—WISCONSIN RAPIDS 54494
District State Office Building
1681 Second Ave S; PO Box 277
Tel 715/423-4730

No 7—RHINELANDER 54501
Schiek Plaza; PO Box 697
Tel 715/369-2840

No 8—Information should be obtained from Eau Claire District

Note: Use box numbers on First Class Mail

DIVISION OF HEALTH
Regions

DIVISION OF COMMUNITY SERVICES

(formerly Divisions of Family Services, Mental Hygiene, and Aging)

State Office: 1 W Wilson St, Madison, Wis 53702.
Tel: 608/266-2701

Administrator 266-2701
Leonard J Ganser, MD

Deputy Administrator 266-9648
Paul R Keys

Assistant Administrator for Regional Operations 266-9879
John Erickson

Assistant Administrator for Program 266-2722
Jerry Foy

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Alternate Care **266-3443**
Severa Austin, Director

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Office of Program Support ..**266-3032**
Ken Kringle, Interim Director

Alcohol and Other Drug Abuse **266-3442**
Larry Monson, Director

Mental Health **266-2719**
William Buzogany, Director

Children, Youth and Families **266-3036**
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Office of Regional Support .**266-9707**
William Griffin, Director

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718 West Clairemont Ave
Box 228
Tel 715/835-6151

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Lewis McCauley, Director
1181 Western Ave
Box 3730
Tel 414/494-9641

MADISON 53704
Rex Duter, Director
3601 Memorial Drive
Tel 608/249-0441

MILWAUKEE 53203
Gerald Berge, Director
819 North 6th St
Tel 414/224-4501

WAUKESHA
John Bauer, Director
819 North 6th St
Milwaukee 53203

RHINELANDER 54501
Robert Heide, Director
Schiek Plaza, Box 697
Tel 715/362-7800

DISTRICT OFFICES

FOND DU LAC 54935
485 South Military Road
Box 1069
Tel 414/922-6810

ASHLAND 54806
601 2nd St, West
Tel 715/682-3405

WISCONSIN RAPIDS 54494
1681 Second Ave, South
Box 636
Tel 715/423-4305

LaCROSSE 54601
3550 Mormon Coulee Road
Box 743
Tel 608/788-7000

DIVISION OF ECONOMIC ASSISTANCE

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Tel: 608/266-3416

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- Staff Support
  Marlene Heiser, Asst Director
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DIVISION OF VOCATIONAL REHABILITATION

State Office: 131 W Wilson St, Madison, Wis 53702. Tel: 608/266-1281

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- Business Enterprise Program 266-1116
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- Workshop for the Blind
  5316 W State St, Milwaukee 53208
  Tel 414/771-5311

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Vacancy, Director

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Waukesha 53186
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3555 S 27th St
Milwaukee 53221
Tel 414/643-1919

Robert Barbee, Acting Supervisor
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Racine 53403
Tel 414/636-3388

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Department of Industry, Labor and Human Relations

PO Box 2209, 201 E Washington Ave, Madison, Wis 53701

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Administration 266-1024
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Manpower Services 266-5534
Edwin M Kehl, Acting Administrator

BUREAU OF HEALTH STATISTICS

DIVISION OF HEALTH

The Bureau is the custodian of birth, death, marriage, and divorce records for the state. Also, the Bureau has contracts with the National Center for Health Statistics, Cooperative Health Statistics System for the collection of data on health manpower, facilities, and vital statistics. Several other projects are being carried out in areas such as cancer reporting, emergency medical care, and hospital discharge data. Another of the Bureau's activities is the production of annual population estimates for Wisconsin counties . . . a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: Raymond D Nashold, Director, Bureau of Health Statistics, PO Box 309, Madison, Wis 53701.

WORKER'S COMPENSATION AND THE PHYSICIAN

MOST WISCONSIN PHYSICIANS become involved with treatment of patients covered by Worker's Compensation, which provides payment of compensation for disability, and for medical expenses necessary because of injury or illness arising out of employment.

The State Medical Society's Committee on Occupational Health, which maintains liaison with the Worker's Compensation Division, offers the following helpful information:

Filing reports. Filing reports is a direct responsibility of any physician who treats patients under the Worker's Compensation Program. WC-16 Medical Report on Industrial Injury is to be completed on a work-related injury or illness when the disability exceeds three weeks or when any permanent disability results therefrom. WC-16 is available from the insurance carrier or from WC Division. (The Committee on Occupational Health presently is involved in revising WC-16.) Information reported is used by the WC Division to determine the amount of compensation payable to the disabled worker.

Estimating disability. Learn to estimate disability according to standards set up by the WC Division. Other standards or schedules are fine for physicians' own information, but only the WC Division's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 BLUE BOOK, pp 43-45).

Completing reports. Complete report forms carefully and fully. Learn terminology of the statutes concerning compensable employment disability.

Submitting reports. Submit reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. An unexpected misfortune may place the employe in urgent need of compensation.

Payment for reports. Occasionally physicians request reimbursement for preparing and filing reports. The Committee on Occupational Health wishes to restate the following principles:

—Simplified reports including first, progress, and final reports: No charge.
—WC-16 Report: No charge.
—When special reports are requested by the WC Division, or the insurance carrier requires an extensive or extra-ordinary report in lieu of a simplified report, a reasonable charge for preparation and filing is appropriate.

Don't be afraid to ask questions. Contact either the State Medical Society or Hugh Russell of the Worker's Compensation Division, 201 East Washington Ave, Box 2209, Madison, Wis 53707 (tel 608/266-1340).

Health Policy Council

Chairman, HPC
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Tel 715/387-5275 or 387-1711

Secretary, HPC
Robert Durkin, Madison 53701
Tel 608/266-1511

Gerald Agamaite DDS, Oconto Falls 54154
Tel 414/846-2171

*Eugene Arnett, Medford 54451
Tel 715/748-2600

Roger Baird, Menasha 54952
Tel 414/734-8960

Edith Bingham, Wisconsin Rapids 54494
Tel 715/423-9405

William Blockstein, PhD, Madison 53706
Tel 608/262-3480

*Myrvin Christopherson, PhD, Stevens Point 54481
Tel 715/341-0352

Kenneth Clark, Milwaukee 53213
Tel 414/771-0700

*Bruno DeRosso, Hurley 54534
Tel 715/561-2702

Dolores Ecker, Chilton 53014
Tel 414/439-1260

Belle Fiedler, Madison 53711
Tel 608/274-1818

*Terms expire June 30, 1978; Governor will be making appointments later this year.

Mary Hanrahan, Muscoda 53573
Tel 608/739-3320

*Elaine Keller, Milwaukee 53222
Tel 414/466-3494

*Frank Kosednar, Milwaukee 53202
Tel 414/271-1444 ext. 375 or 271-2844

*Albert Lahmayer, OD, Black River Falls 54615
Tel 715/284-2494

Charles Laible, Superior 54880
Tel 715/392-8281

Reverend Calvin Larson, Oshkosh 54901
Tel 414/235-4653

Barry Lloyd, Kenosha 53140
Tel 414/658-3821

Della Lowe, Lyndon Station 53944
Tel 608/254-7935

*David Markert, PhD, Centuria 54824
Tel 715/646-2378

William Merchant, MD, Madison 53705
Tel 608/256-1901 ext. 211

Margaret Miller, Milwaukee 53233
Tel 414/271-8181

*Rose Nammacher, Oconomowoc 53066
Tel 414/567-3915

Loretta Nikolai, Platteville 53818
Tel 608/348-3105

Frank Papenfuss, LaCrosse 54601
Tel 608/784-8600

John Peters, MD, Fond du Lac 54935
Tel 414/922-3700

Roberta Peterson, Eau Claire 54701
Tel 715/832-4786

Marian Piper, Madison 53702
Tel 608/266-3034

Walter Rattan, MD, Kenosha 53140
Tel 414/654-6023 or 654-5155

Dale Robinson, Chippewa Falls 54729
Tel 715/723-4437

Werner Schaefer, Milwaukee 53201
Tel 414/264-3067

Flora Seefeldt, Milwaukee 53211
Tel 414/963-5752

*Louis Slimmer, Hayward 54843
Tel 715/634-4465

Ellen Smith, River Falls 54022
Tel 715/425-6383

Frank Snapp, Grantsburg 54840
Tel 715/463-5353

*Kit Sorenson, Neenah 54956
Tel 414/725-3041

Patricia Stone, Green Bay 54304
Tel 414/494-6788

*Richard Szczepkowski, Sheboygan 53081
Tel 414/457-5365

*Earl Thayer, Madison 53701
Tel 608/257-6781

Betty Thompson, Milwaukee 53202
Tel 414/272-2642

Alma Vasquez, PhD, Milwaukee 53217
Tel 414/278-0701

*Warren Von Ehren, Madison 53711
Tel 608/274-1820

Anneliese Waggoner, DePere 54115
Tel 414/336-0577

*Hilary Waukau, Sr., Keshena 54135
Tel 715/799-3311

*Selma Weiskopf, RN, Janesville 53545
Tel 608/754-5417 ■

Amended rule on amphetamines effective June 1, 1978

EFFECTIVE NOVEMBER 1, 1977 virtually all sales and prescriptions of amphetamines were banned in Wisconsin in an action taken by the State Medical Examining Board. This action created considerable debate, resulting in a public hearing by the MEB in January 1978. Following the hearing the MEB amended Chapter Med 10.02(2)(s) of the Wisconsin Administrative Code to include only certain Schedule II controlled substances. The amended rule, which became effective June 1, 1978, reads as follows (with the amended portion appearing in italics):

UNPROFESSIONAL CONDUCT DEFINED

Med. 10.02(2) (s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, *sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Wis. Stats.* to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, *or for the treatment of epilepsy,* or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun.

(INFORMATIONAL NOTE: The following list, although not exhaustive or exclusive, does include most of the brand-name drugs available in the United States as of March 1, 1978, which fall within the definition of ch. 10.02(2)(s): Benzedrine, Biphetamine, Delcobese, Desoxyn, Dexamyl, Dexedrine, Eskatrol, Fetamin, Obetrol, Obotan, and Preludin).

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(listed by district and serving the counties of)

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2	**SOUTHEASTERN WISCONSIN HEALTH SYSTEMS AGENCY, INC (SEWHSA)** 735 North 5th Street Milwaukee, Wisconsin 53203	Mrs Flora Cohen, President Russell Julian, Executive Director Telephone: 414/271-9788	Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha
3	**LAKE WINNEBAGO AREA HEALTH SYSTEMS AGENCY, INC (LWAHSA)** 404 North Main, Room 140 Oshkosh, Wisconsin 54901	Carl Steffin, President Jerry Alexander, Executive Director Telephone: 414/231-2907	Calumet, Fond du Lac, Green Lake, Marquette, Outagamie, Waupaca, Waushara, and Winnebago
4	**NORTHEASTERN WISCONSIN HEALTH SYSTEMS AGENCY, INC (NEWHSA)** Rice Building, 828 Cherry Street Green Bay, Wisconsin 54301	William W Grover, Jr, MD, President Dennis Riker, Executive Director Telephone: 414/432-5284	Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, and Sheboygan
5	**WESTERN WISCONSIN HEALTH SYSTEMS AGENCY, INC (WWHSA)** 1707 Main Street La Crosse, Wisconsin 54601	Harold Ristow, President Val Chilsen, Executive Director Telephone: 608/785-9352	Barron, Buffalo, Chippewa, Clark, Crawford, Dunn, Eau Claire, Jackson, LaCrosse, Monroe, Pepin, Pierce, Polk, Rusk, St. Croix, Trempealeau, and Vernon
6	**NORTH CENTRAL AREA HEALTH PLANNING ASSOCIATION, INC (NCAHPA)** 811 North First Avenue, Room 27 Wausau, Wisconsin 54401	Paul Lidral, President George Snyder, Executive Director Telephone: 715/845-3107	Adams, Florence, Forest, Juneau, Langlade, Lincoln, Marathon, Oneida, Portage, Taylor, Vilas, and Wood
7	**HEALTH SYSTEMS AGENCY OF WESTERN LAKE SUPERIOR, INC** Ordean Building, Suite 202 424 W Superior Street Duluth, Minnesota 55802	George Knabe, Jr, MD, President Ivan J Fahs, Executive Director Telephone: 218/727-8371	*Wisconsin Counties:* Ashland, Bayfield, Burnett, Douglas, Iron, Price, Sawyer, and Washburn *Minnesota Counties:* Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis ■

SMS Quality Care Division has a complete listing of all members of the HSAs.

MD MEMBERS OF WISCONSIN HEALTH SYSTEMS AGENCY BOARDS

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HEALTH PLANNING COUNCIL, INC

**Curtis Bush*, MD, 1200 N Center St, Beaver Dam 53916
William Merchant, MD, Medical Director VA Hospital 2500 Overlook Tr Madison 53705
**Ihor Galarnyk*, MD, Plain 53577
**Donald T Fullerton*, MD, 610 N Walnut St, Madison 53706

District 2

SOUTHEASTERN WISCONSIN HEALTH SYSTEMS AGENCY, INC

**Robert R Cadmus*, MD, 756 N Milwaukee St, Milwaukee 53202
**William J Madden*, MD, 4707 Lighthouse Dr, Racine 53402
**Robert C Feulner*, MD, 611 Westminster Dr, Waukesha 53186
**William E Finlayson*, MD, 2003 W Capitol Dr, Milwaukee 53206
**Edward Lennon*, MD, Associate Dean, Medical College of Wisconsin, 561 North 15th Street, Milwaukee 53233
Constantine Panagis, MD, 841 N Broadway St, Milwaukee 53202
**Walter Rattan*, MD, 6530 Sheridan Rd, Kenosha 53140
**Henry Twelmeyer*, MD, 2500 N Mayfair Rd, Milwaukee 53226
John R Petersen, MD, Director of Medical Services, Milwaukee County Institutions and Departments, 8700 West Wisconsin Avenue, Milwaukee 53226

*Denotes member of SMS

Note: Michael W McManus, Exec Dir Med Soc of Milwaukee Co is a member of above District (411 East Mason St, Milwaukee 53202)

District 3

LAKE WINNEBAGO AREA HEALTH SYSTEMS AGENCY, INC

**Robert Carlovsky*, MD, 222 Cottage Ave, Fond du Lac 54935
**James L Basiliere*, MD, 515 Doctors Ct, Oshkosh 54901
**James E Murphy*, MD, 424 E Wisconsin Ave, Appleton 54911
**Curtis Baltz*, MD, Nicolet Clinic, 411 Lincoln, Neenah 54956

District 4

NORTHEASTERN WISCONSIN HEALTH SYSTEMS AGENCY, INC

**William W Grover, Jr*, MD, Bonduel 54107
**David E Papendick*, MD, 801 Fourth Street, Algoma 54208
**Bruce Bressler*, MD, 3133 Term Ct, Green Bay 54302

District 5

WESTERN WISCONSIN HEALTH SYSTEMS AGENCY, INC

**Robert M Anderson*, MD, Cumberland Clinic, Cumberland 54829
**James R Beix*, MD, 409 Spruce Street, River Falls 54022
**David E Goodnough*, MD, Gundersen Clinic, La Crosse 54601
**Donald R Griffith*, MD, 733 W Clairemont Avenue, Eau Claire 54701
**David E Westgard*, MD, 815 S 10th Street, La Crosse 54601
**Elmer P Rohde*, MD, 815 South 10th Street, La Crosse 54601

District 6

NORTH CENTRAL AREA HEALTH PLANNING ASSOCIATION, INC

**Michael K Mikkelson*, MD, 1205 O'Day Street, Merrill 54452
**Henry J C Schwartz*, MD, Lakeland Medical Associates, Woodruff 54568
**Michael T Wood*, MD, Marshfield Clinic, Marshfield 54449

District 7

HEALTH SYSTEMS AGENCY OF WESTERN LAKE SUPERIOR, INC

**Joseph Jauquet*, MD, 200 7th Avenue West, Ashland 54086
Enzo Krahl, MD, 3 White Birchtrail, Superior 54880
Oskar Friedlieb, MD, 307 First Street North, Virginia, MN 55792
John LaBree, MD, 2205 East 5th Street, Duluth, MN 55812
George Knabe, Jr, MD, 2616 E Third Street, Duluth, MN 55812
Harold Leppink, MD, St Louis Co Health Dept, 504 East Second Street, Duluth, MN 55805
Josiah Fuller, MD, 400 East Third Street, Duluth, MN 55805
Duane Person, MD, East Range Clinic, Ltd, Virginia, MN 55792 ■

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Title 19 provider contract mailed to physicians

The Wisconsin Department of Health and Social Services (DHSS) mailed all physicians a "provider contract" last month concerning their participation in the Title 19 Medical Assistance Program.

State law requires physician/providers to sign this contract if they wish to be reimbursed for the services they render to Title 19 recipients. If a physician choses not to sign the contract, he or she will not be reimbursed for services under the Title 19 program.

This contract is effective from July 1, 1978 until after the Medical Assistance Super-Rule is promulgated by DHSS; thus this contract binds physicians only to existing rules and laws relative to the Title 19 program, not future, unknown rules or regulations.

The Society and its political-action Division, the Physicians Alliance, have spent months negotiating the terms of this provider contract and the special cover letter attached to it with the Department of the Health and Social Services and other Title 19 providers including hospitals, nursing homes, nurses, optometrists, psychologists, transportation operators, pharmacists, and others.

Regional meetings conducted by SMS staff are being held throughout the month of June to familiarize physicians with the contract and its provisions. ■

Joint Cost Committee votes to extend membership

The Joint Voluntary Effort on Cost Containment of the State Medical Society/Wisconsin Hospital Association voted May 15 to increase its committee membership to include representatives of third-party payers, private industry and labor suppliers, and possibly others.

The SMS/WHA Voluntary Effort is the Wisconsin counterpart of the national Voluntary Effort of the AMA/AHA which is aimed at reducing the rate of increase in hospital expenditures throughout the nation in order to prevent the necessity of imposition of federal controls.

The Committee voted to begin preparing a set of goals and objectives for the Joint Voluntary Effort in Wisconsin based on the recommendations of the National Commission on the Cost of Medical Care and the recently adopted resolution of the WHA Board of Directors relative to cost containment.

The Committee also agreed to establish specific criteria for the collection of data on hospital expenditures and revenues so that the Joint Committee can adequately track the movements of indicators of utilization, expenditures, admissions, income, etc, in relation to the goals and objectives of the voluntary cost containment effort.

In a related development, the U S Department of Health, Education, and Welfare has asked the Justice Department to delay granting the nation's hospitals an antitrust law exemption in order to carry out the Voluntary Effort of the American Medical Association and the American Hospital Association.

J A McMahon, president of the American Hospital Association, said, "It seems passing strange that HEW would undermine and even try to undercut our Voluntary Effort."

HEW told the Justice Department in a letter that the Voluntary Effort might discriminate against smaller community hospitals and HMOs and also might hold down wages of hospital workers. The Justice Department said it would take no action until it had met with HEW during the week of May 29. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.33 as of April 28, 1978. ■

Elsewhere in this issue there is an article, "A basic overview of EDS Federal's computerized claim processing system," which may be helpful to physicians' office staffs.

DHSS, EDS-Federal Medicaid performance criticized

Physicians, pharmacists, clinic managers, hospital administrators, and nursing home personnel all voiced their concerns with the efficiency of claims processing in Wisconsin's Medical Assistance Program at a May Assembly hearing in Madison.

Rep Joseph Czerwinski, chairman of the Assembly's Health and Social Services Committee, called the hearing to listen to testimony on the performance of the Department of Health and Social Services and the Medicaid fiscal intermediary—EDS-Federal in the state Medicaid program.

The State Medical Society of Wisconsin submitted a formal statement on physicians' experiences to date with the administration of the Medical Assistance Program at that hearing. The statement cited that since EDSF took over administration of the program ten months ago, "there continue to be significant problems, both within the Department and within EDSF, that prevent this program from winning or deserving acceptance from physicians."

The Society said there has been no acceptable or effective solution of the huge pre-July backlog, nor does one appear to be in the offing. In addition, the procedure coding problems within EDSF "are something of a nightmare" and eligibility and other insurance problems "continue to plague the system."

In its statement the Society requested that DHSS and EDSF work jointly with providers to identify and resolve problems prior to the Department implementing its own solutions. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of May 8, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

BROWN

Calaguan, Raymond R, 835 S Van Buren, Green Bay 54305 (1938, Regular, Radiology/Nuclear Medicine)

DANE

Berkoff, Herbert A, 1300 University Ave, Madison 53706 (1937, Regular, Cardiovascular Surgery/Thoracic Surgery, Certified-TS)

DeAngelis, Catherine, 1552 University Ave, Madison 53706 (1940, Regular, Pediatrics, Certified)

Grab, David S, 1 S Park St, Madison 53715 (1927, Regular, General Practice)

Kasuboski, David A, 20 S Park St, Madison 53715 (1942, Regular, Psychiatry, Certified)

Lloyd, Ricardo V, 3104 Bluff, #4, Madison 53705 (1945, Resident, Pathology)

Lubar, Howard S, 20 S Park St, Madison 53715 (1938, Regular, Neurology)

Murphy, M John, 20 S Park St, Madison 53715 (1941, Regular, Neurology)

Stainer, Gregory A, 2833 Eggimann Rd, Madison 53713 (1950, Resident, Ophthalmology)

Tibbetts, James C, 20 S Park St, Madison 53715 (1938, Regular, Neurological Surgery, Certified)

Tunca, Josh C, 1300 University Ave, Madison 53706 (1943, Regular, Obstetrics and Gynecology, Certified)

DOUGLAS

El-Wakil, Mamdouh E, 2606 Hammond Ave, Superior 54880 (1942, Regular, Family Physician, Certified-PTH)

Reich, Lawrence F, 318 21st Ave, E, Superior 54880 (1948, Regular, Emergency Medicine)

EAU C'AIRE-DUNN-PEPIN

Beck, Mohamed X I, 404 Country Club Lane, Altoona 54720 (1943, Regular, Neurological Surgery)

GREEN

Zach, Robert G, Rte #2, Monroe 53566 (1925, Regular, Radiology, Certified)

MILWAUKEE

Baker, Vance L, 4808 W Lloyd St, Milwaukee 53208 (1906, Regular, General Practice)

Beckes, Robert J, 5032 W Forest Home Ave, Milwaukee 53219 (1940, Regular, Plastic Surgery, Certified)

Gonzalez, Ramon A, 2120 W Fond du Lac Ave, Milwaukee 53210 (1926, Regular, Diagnostic Radiology/Nuclear Medicine)

Kretchmar, Morris, 2202 W Silver Spring Road, Milwaukee 53209 (1904, AMA Age Exempt, General Practice)

Lerner, Neil A, 6723 W Lloyd St, Wauwatosa 53213 (1950, Resident, Internal Medicine)

Luckey, William T, 1545 W Spruce Ct, River Hills 53217 (1932, Resident, Radiology/Psychiatry, Certified-P)

Misra, Suresh K, 8410 W Cleveland Ave, West Allis 53227 (1949, Regular, Family Physician)

Riegan, Jan, 2961 N 50th St, Milwaukee 53210 (1942, Resident, General Surgery)

Sortor, Ralph F, 10691 W Parnell Ave, Hales Corners 53130 (1926, Regular, Obstetrics and Gynecology, Certified)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BARRON-WASHBURN-BURNETT

Matson, Kenneth L, Sun City, AZ, to Rte 1, Box 225, Sarona 54870

CHIPPEWA

Sazama, Frank B, Sun City, AZ, to Hotel Northern, Chippewa Falls 54729

DANE

Crowley, Lawrence G, Madison, to Stanford University Medical School, Stanford, CA 94305

McKenna, Patrick J, Madison, to 11424 Sahler St, Omaha, NE 68164

FOND DU LAC

Kief, Harold J, Fond du Lac, to Rte 1, Box 1502, Rhinelander 54501

GREEN

Estes, Glen, Monroe, to Rte 1, Box 143A, New Glarus 53574

Estes, Jeanne M, Monroe, Rte 1, Box 143A, New Glarus 53574

JEFFERSON

Netzow, Earl J, Lake Mills, to Rte 1, Box 51F, Cedar Grove 53013

MILWAUKEE

Morgan, Sherburne F, Crowley, TX, to 9470 Marin Road, Roswell, GA 30076

ROCK

Lamphere, Richard L, Janesville, to 101 Golf Terrace, Dr, Crookston, MN 56716

DEATHS

Midelfort, Peter A, Eau Claire-Dunn-Pepin County, Apr 16, 1978

Goldberg, Nat, Milwaukee County, Apr 17, 1978 ■

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OBITUARIES

◈County, State, AMA Members

Raymond T Shima, MD, 70, Rocky Ford, Colo, died Dec 21, 1977. Born Nov 13, 1907 in Montgomery, Minn, Doctor Shima practiced medicine in Turtle Lake for a number of years and moved to Rocky Ford in 1947. Surviving is his widow, Elizabeth.

William G Bernhard, MD, Summit, New Jersey, died Dec 31, 1977 in Summit, New Jersey. Surviving are his widow, Elizabeth and a son, Dr William N Bernhard of New York City.

◈ **Edmund A Brzezinski, MD,** 81, Milwaukee, died Mar 3, 1978 in Milwaukee. Born Nov 7, 1897 in Milwaukee, Doctor Brzezinski graduated from Marquette University Medical School in 1922. He had served on the medical staffs of St Luke's and St Francis hospitals in Milwaukee. Surviving are several nieces and nephews.

◈ **Albert Hogeland Pemberton, MD,** 55, Fox Point and Vero Beach, Fla, died Mar 6, 1978 in Fox Point. Born June 16 1922 in Rochester, Minn, Doctor Pemberton graduated from Northwestern University Medical School in 1947. He completed his general and thoracic surgery fellowship at the Mayo Clinic, Rochester, Minn, in 1956 and moved to Milwaukee where he organized the heart surgery program at Deaconess Hospital. He served as a general surgeon in the United States Army Medical Corps from 1952-54. Doctor Pemberton served on the medical staffs of Columbia, Deaconess, Mt Sinai, St Anthony's, St Luke's, St Mary's, St Michael, Children's, Family, Elmbrook Memorial and Trinity Memorial hospitals. He also was an associate clinical professor of surgery at the Medical College of Wisconsin. Doctor Pemberton retired from medical practice in 1976 due to ill health.

Surviving are his widow, Nancy; two sons, Dr John, Rochester, Minn, and David, Milwaukee; and one daughter, Anne, who attends Johns Hopkins University in Baltimore, Md.

Herbert W Granzeau, MD, 72, Burlington, died Mar 25, 1978 in Burlington. Born Dec 27, 1905 in Sugar Creek, Doctor Granzeau graduated from the University of Wisconsin Medical School in 1931. He had practiced medicine in Burlington for 42 years and at one time was chief-of-staff of Burlington Memorial Hospital. Surviving are his widow, Dayle; two sons, Peter, Hampton, Va, and Timothy, Springfield, Ill; and a daughter, Mrs Gerald (Penelope) Egbert, Vancouver, Wash.

Haydon R Duffy, MD, 55, Fox Point, died Mar 31, 1978 in Milwaukee. Born Mar 21, 1923 in Fond du Lac, Doctor Duffy graduated from St Louis University Medical School in 1949. He served in the United States Navy as a flight surgeon in World War II and the Korean War. Doctor Duffy served on the medical staff of St Mary's Hospital and was a member of the board of directors of Personal Indemnity Mutual Insurance Co. Surviving are his parents, reserve Federal Judge F Ryan and Louise Duffy, Milwaukee. ■

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All of these speakers expressed the concern that women be told about the various options that are now becoming available for the treatment of breast cancer. They especially stressed the need to permit patients to ask questions and explore these possibilities. They suggested that if a woman is not satisfied with the options one physician or surgeon offers her, she should seek a second opinion. Because the newer treatments involving radiotherapy and chemotherapy may require very specialized expertise, you may desire to consult with physicians at the Wisconsin Clinical Cancer Center to determine if any of these alternatives are possible for your patient.

Physicians have now had enough experience with the various modalities —surgery, radiotherapy, and chemotherapy—that they should look closely at the results they have obtained with their breast cancer patients and see if there are other ways to reduce the physical trauma and morbidity for some women while still giving them adequate and often curative treatment.

—Dorothy J Buchanan-Davidson, PhD.
Science Writer ■

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WMJ-68

CONTINUING MEDICAL EDUCATION
MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 WISCONSIN

June 20-July 1: *Wisconsin Society of Obstetrics and Gynecology,* Eagle Waters Resort, Eagle River, Wis 54521

June 23-25: *Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians* at The Hilton Hotel, Eau Claire, Wis. Ten hours of CME and AAFP prescribed credit. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

Aug 17-19: *Primary Care—A View toward the 80's* at Interlaken Lodge/Villas, Lake Geneva, Wis. Dept. of Medical Education, Ravenswood Hospital Medical Center, 4550 N. Winchester at Wilson, Chicago, Ill 60640. Contact: Mara Harrington, Secretary, tel: 312/878-4300. CME Category I credit by the AMA. g6-7/78

Sept 15-16: *Wisconsin Surgical Society,* Holiday Inn, Wausau, Wis 54401

Sept 15-16: *Wisconsin Neurosurgical Society,* Gundersen Clinic, LaCrosse, Wis 54601

Sept 23-24: *Wisconsin Society of Anesthesiologists,* Playboy Club, Lake Geneva, Wis 53147

Oct 14: *Wisconsin Radiological Society,* The Concourse, Madison, Wis 53701

Oct 16: *Milwaukee Academy of Medicine,* University Club of Milwaukee, Milwaukee, Wis 53202

Oct 27-28: *Wisconsin Chapter, American College of Emergency Physicians,* Red Carpet Inn, Milwaukee, Wis 53202

Nov 3: *Pediatric Emergencies,* Fall Pediatric Day, Wisconsin Chapter, *American Academy of Pediatrics,* Wisconsin Center, Madison, Wis 53706

Nov 18: *Wisconsin Dermatological Society,* Milwaukee County General Hospital, Milwaukee, Wis 53202 19104.

1978 NEIGHBORING

Sept 7-11: *Medical Knowledge Self-Assessment Program Course,* Towsley Center, Ann Arbor, Mich. Info: Registrar, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Sept 26-30: *Medical Knowledge Self-Assessment Program Course,* Mayo Civic Auditorium, Rochester, Minn. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

Oct 10-14: *Medical Knowledge Self-Assessment Program Course,* Ambassador West Hotel, Chicago, Ill. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa

Oct 21-25: Annual Convention, Indiana State Medical Association, at Marriott Inn, Clarksville, Ind 47130

FAMILY MEDICINE

Topic: *Primary Care—A View Toward the 80's*

Aug 17-19, 1978

Interlaken Lodge/Villas,
Lake Geneva, Wisconsin

For: Family Physicians, Internists and Pediatricians, 3 one-half days conference. 15 hours of instruction; CME Credit Category I AMA.

Fee: $80.00

Sponsored by Department of Medical Education, Ravenswood Hospital Medical Center, 4550 N Winchester at Wilson, Chicago, Ill 60640.

Contact: Mara Harrington, Secretary

Telephone: 312/878-4300

6-7/78

1978 OTHERS

June 17-18: Fifth Annual UCLA Biofeedback Seminar: *Practical Applications of Biofeedback in the Health Sciences,* at Los Angeles Marriott Hotel, Los Angeles, Calif. Approved for 12½ hours of Category I credit toward CMA Certificate in CME and the AMA Physicians Recognition Award. Fee: $185. Info: Health Sciences, UCLA Extension, PO Box 24902, Los Angeles, CA 90024 or call 213/825-5840. g3-5/78

Sept 18-21: *Pulmonary Medicine—An Update for the Clinician.* American College of Chest Physicians, The Mark Resort, Vail, Colo.

Sept 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

STATE MEDICAL SOCIETY OF WISCONSIN

Dates and Locations of Annual Meetings

1979-1987

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel.

1979—May	**10-12**
1980—March	**27-29**
1981—March	**26-28**
1982—April	**15-17**
1983—March	**24-26**
1984—March	**29-31**
1985—March	**28-30**
1986—April	**17-19**
1987—March	**26-28**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Dates 1979 through 1981 have been approved by House of Delegates action; dates 1982 through 1987 have been tentatively approved by Council action and will be reviewed and acted on by the House of Delegates.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1978 Meeting Dates/Sites

Sept 18-21: American College of Chest Physicians, The Mark Resort, Vail, Colo.

Sep 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

June 12-July 9
Blood Components & Their Application, with Harold A Oberman, MD, Professor of Pathology, Director, Blood Banks and John A Penner, MD, Professor of Internal Medicine, Director, Coagulation Unit both at the University of Michigan Medical Center, Ann Arbor, Michigan. This program is co-sponsored by the Department of Postgraduate Medicine and Health Professions Education at the University of Michigan Medical Center for Category 1 credit and accepted by the AAFP for Prescribed credit.

July 10-Aug 6
The Five Phases of Acute Myocardial Infarction, with J O'Neal Humphries, MD and Bernadine H Bulkley, MD both of the Johns Hopkins Hospital and School of Medicine, Baltimore, Maryland. This four-part telecourse is co-sponsored for Category 1 credit by the American Heart Association and is accepted for Prescribed credit by the AAFP.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

1978 OTHERS

Dec 5-9: *Fluid and Electrolyte Balance, Hypertension and Renal Disease,* American College of Physicians Postgraduate Course, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Ill. AMA-PRA Category I credit approved. Info: Registrar, ACP, 420 Pine St, Philadelphia, Pa 19104.

ASPEN MUSHROOM CONFERENCE

Identification of edible, poisonous, and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA category I. August 13-18, 1978. Wildwood Inn, Snowmass-at-Aspen, Colorado. Contact Beth Israel Hospital, 1601 Lowell Blvd, Denver, Colo 80204. Tel: 303/825-2190, ext 359. 5-6/78

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS

. . . is a non-dues-paying organization of PHYSICIANS AND DENTISTS who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held at the Sheraton-Southfield Hotel, Southfield, Mich, Aug 3-6, 1978. Tax deductible. Inquirers and newcomers welcome. For info: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511.

American Society of Internal Medicine Future meetings:

Sept 26-29, 1978	Interim Meeting	Orlando, Florida
April 26-29, 1979	Annual Meeting	New Orleans, Louisiana
Sept 28-29, 1979	Interim Meeting	Las Vegas, Nevada
May 15-18, 1980	Annual Meeting	Washington, DC
Sept 26-27, 1980	Interim Meeting	San Diego, California
April 30—May 3, 1981	Annual Meeting	Denver, Colorado

CONTRIBUTIONS—CES FOUNDATION April 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1978.

Unrestricted

Anonymous; RL Waffle, MD; Sheboygan County Medical Auxiliary; Trempealeau, Jackson, Buffalo County Medical Auxiliary; Winnebago County Medical Auxiliary; Columbia, Marquette, Adams County Medical Society—*Voluntary Contributions*

Restricted

Marathon County Medical Auxiliary; LH Wurman, MD; Paul Z Han, MD; Ivan Stanko, MD—*Marathon County Medical Auxiliary Student Loan Fund*
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MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. The Editorial Board reserves the right to limit manuscripts to two printed pages, with additional pages to be subsidized by the author(s) on the basis of $100 per page. A maximum of four illustrations and/or tables may be included; additional ones will be charged to author(s) at cost. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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RESPONSIBILITY. Publication of the WISCONSIN MEDICAL JOURNAL is under the direction of the Editorial Board whose policies are approved by the Council of the State Medical Society of Wisconsin. The Medical Editor is chairman of the Editorial Board. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production and business operation of the JOURNAL, as well as final responsibility of the entire publication.

Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

ADVERTISEMENTS. The acceptance of advertising in the WISCONSIN MEDICAL JOURNAL is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Socity of Wisconsin. The JOURNAL reserves the right to accept or reject advertising copy for any reason. Advertising rates will be furnished on request.

CIRCULATION. Members of the State Medical Society of Wisconsin receive the WISCONSIN MEDICAL JOURNAL each month. The cost of the Journal for members ($5.00 per year) is included in dues. Non-members may subscribe at the following rates: $10.00, one year; $1.50, single copy; $3.00, previous years; $5.00, Annual Blue Book. The JOURNAL reserves the right to control its circulation.

INDEXING. The WISCONSIN MEDICAL JOURNAL is indexed in "Index Medicus" and "Hospital Literature Index," and its contents page appears regularly in "Current Contents/ Clinical Practice." ■

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The acceptance of advertising in the *Wisconsin Medical Journal* is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The Journal reserves the right to accept or reject advertising copy *for any reason.*

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2. Unfair comparisons and disparagment of a competitor's goods will not be allowed.
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4. Advertising copy will not be accepted if, in the opinion of the Bureau or the management of the medical journal, the copy (a) appears to violate the Principles of Medical Ethics of the American Medical Association or of a state medical association, (b) is indecent or offensive in any way, (c) contains attacks of a personal, racial or religious character, or (d) appears to be contrary to any regulation or law for the prevention of discrimination, or (e) contains claims found by any court or federal or state agency to be invalid or in violation of law.
5. Advertisers and advertising agencies agree to protect and indemnify both Bureau and any medical journal represented by Bureau against any and all liability, loss or expense arising from claims for libel, unfair competition, unfair trade practice, infringement of trade-marks, trade names or patents, copyrights or proprietary rights, violations of rights of privacy and any other claims resulting from any advertisement submitted to the Bureau or published in any such medical journal.

The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.

PSROs ARE FEDERAL AGENCIES, JUDGE RULES

A federal judge in Washington DC has ruled that Professional Standards Review Organizations (PSROs) are agencies of the federal government and as such must comply with the Federal Freedom of Information Act. US District Judge Gerhard Gesell said because PSROs receive federal funds and were created under a federal statute, they must be considered agencies subject to disclosure of public records.

The ruling makes public all records of the PSRO except those involving the individual physician-patient relationship are exempt from the FOIA. Gesell's decision comes in a suit brought under the FOIA by the Public Citizen Health Research Group, a Ralph Nader organization, for access to documents from the National Capital Medical Foundation, Inc, a Washington PSRO.

The Department of Health, Education, and Welfare recently announced plans to appeal Judge Gesell's decision.

A DISCUSSION OF THE COUNTERSUIT QUESTION: NOW AVAILABLE

"Countersuit"—the filing of a cross-complaint against the patient's attorney in a malpractice action—is discussed in a paper recently prepared by the SMS Medical Defense Committee entitled: "Memorandum on Countersuit in Wisconsin." The paper explains why countersuits and a legal negligence standard for attorneys have not been established in Wisconsin.

A general frivolous lawsuit standards, Assembly Bill 237, Chapter 109, Laws of 1977, has been established, however, and should prove to be an important economic deterrent to attorneys and plaintiffs because *actual* defense costs can be recovered if the court determines that an action constitutes harassment and is without any basis in law or equity. A copy of this statute is included with the "Memorandum on Countersuit in Wisconsin" which is available from the Physicians Alliance Division at SMS headquarters in Madison.

GROUP PRACTICE BOOKLET AVAILABLE

The AMA announces that it has completed its revision of the booklet: "Group Practice: Guidelines to Forming or Joining a Medical Group." The publication was updated recently by representatives of the AMA, the American Group Practice Assn, and the Medical Group Management Assn. Chapters include information on financial and administrative management, characteristics of group practice, and establishing group goals and objectives. Cost of the booklet, OP 456, is $1 for 1-99 copies, and 90¢ for 100-499 copies. Write to the AMA, PO Box 821, Monroe, Wis 53566.

CALIFANO SHOULD CHECK HIS OWN COSTS, NEWSPAPER SAYS

The *Cincinnati Enquirer* recently took exception to HEW Secretary Califano's constant criticism of the high cost of hospital care during a time of general inflation. Califano ought to look in "his own back yard where the cost of government is rising faster than anything he can criticize," the *Enquirer* said, noting that costs of federal, state, and local governments were increasing at a rate of $5.2 million an hour.

Much of this spending is in the form of regulatory activity which results in mounting compliance costs for businesses and professional people, who must pass the costs on to those who buy their products or services. The 41 federal regulatory agencies have a budget of $4.82 billion in fiscal 1979, up from $2.224 billion in fiscal 1974. Complying with the regulations produced by this $4.82 billion operation will cost business about $100 billion, according to the Center for the Study of American Business at Washington University in St Louis. ■

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN MEDICAL JOURNAL
1903 - 1978 75th ANNIVERSARY YEAR

Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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IMPAIRED PHYSICIAN CONFERENCE SLATED FOR OCTOBER

For the past year the State Medical Society has had in operation an Impaired Physicians Program designed to help the doctor who suffers from alcoholism, other drug dependency, or mental illness. Now, physicians and others have an opportunity to learn more about the impaired physician issue, assess the effectiveness of various ongoing programs sponsored by state medical societies, licensing boards and hospitals, as well as participate in discussion groups on all aspects of the issue from prevention through rehabilitation. The AMA's Dept of Mental Health and the Minnesota State Medical Association are sponsoring the Third National Conference on the Impaired Physician, September 29 to October 1, 1978 at the Sheraton-Ritz Hotel in Minneapolis. The conference is open to members of impaired physician committees, licensing boards, hospital medical staffs and administrators, residents and medical students, auxiliary members, medical society staff members, treatment personnel, and other concerned professionals. The conference qualifies for up to 11 hours of Category I credit toward the AMA Physician's Recognition Award. For more information contact the Dept of Mental Health, American Medical Association, 535 N Dearborn Street, Chicago, Ill 60610.

NEW OB/GYN REIMBURSEMENT LEVELS ACCEPTED

An ad hoc committee of the Wisconsin Society of Obstetricians and Gynecologists has accepted a State Department of Health and Social Services proposal for Medical Assistance (Title 19) reimbursement levels for seven obstetrical procedures in Wisconsin. The change in current reimbursement levels for obstetrical services was necessary because of the lack of adequate data in the Medicare (Title 18) Program on which reimbursement levels for Medical Assistance reimbursement is determined. This ad hoc group, representing a cross-section of the State, requested that DHSS continue to advise them in the future regarding any changes in reimbursement levels due to State or Federal actions.

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STATE HEALTH PLAN IN FINAL REVISION PROCESS

The Plan Developing Committee of the Health Policy Council is meeting throughout the summer to revise the latest draft of the State Health Plan. The Committee is rewriting the plan based on testimony accumulated from public hearings around the State. Two SMS physicians have been appointed as physician members of the Plan Developing Committee and are aiding in the revision process. They are Jack Peters, MD, Fond du Lac, and Donald Korst, MD, Madison, both members of the SMS Commission on Health Planning. It is not expected that the Health Policy Council will approve the final State Health Plan until October of this year. ■

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A la carte medicine

PHYSICIAN SUPPORTERS of fee-for-service medicine have to be feeling a bit paranoid lately as the staccato phrases of President Jimmy Carter are added to the voices of countless others decrying those escalating doctor bills. True, our spokesmen have reacted predictably, pointing out the facts of increased costs of rendering health care; but as expected, the rebuttals are relegated to the back pages of the paper.

Most of us believe we are being fair with our periodic fee increases, and we tend to look the other way when we hear of a colleague who takes advantage of the relative value system by submitting an "a la carte" statement of services to the insurance company. Unfortunately, the relative value system has put insurance companies into a bind, because such a system requires that a numerical value be placed upon every service rendered and is incapable of distinguishing situations where each component part, billed separately, can add up to a much higher fee than would be considered fair if the entire service were viewed as a whole.

Two such examples of "a la carte" billing that have surfaced recently illustrate the problems fee-for-service medicine will have to correct if it is to survive: A general surgeon removed 20 lipomata. He simply multiplied the fee for removing a single lipoma (already too high) by 20 and arrived at a total of $1,800.00! A cardiologist found it necessary to perform 35 stress tests on the same patient in a six-month period—at $188.00 per test that came to $6,580.00.

Those are two of the more flagrant recent local abuses of the relative value system. There are many more subtle instances of fee-padding which slip through the system and which can be made to appear legitimate if accompanied by an appropriate code number. Billing separately for services rendered in the ordinary course of postoperative care under the label of intensive care is also highly questionable. Surely common sense must dictate that practices such as that, while they may be legal, are not in the best interests of the profession.

A long time ago James Russell Lowell wrote these words. They still apply.

"In vain we call old notions fudge,
And bend our conscience to our dealing;
The Ten Commandments will not budge,
And stealing will continue stealing."

—WJB

Representation without taxation

THE AMERICAN COLONISTS fought a war because they objected to being taxed without a voice in their government—an action their descendants have hailed with each succeeding generation. But in Wisconsin medical practice, at least, the pendulum has swung too far. Too many Wisconsin physicians receive the benefits of actions taken by the State Medical Society without contributing a cent to cover the expense involved.

In 1976 the State Medical Society membership dues were used to pay $87,042.71 in legal costs alone. In 1977 $46,109.04 were expended. These expenses were incurred in protecting the interests of members and non-members alike. If non-members were to contribute their fair share for those services, we could accomplish a great deal more with less expenditure per physician.

Our Director of Administrative Services would love to divide the total expense figure by the *total* number of Wisconsin physicians and send a bill for that amount to each, but it would be better if we could coax those non-members into the fold. A little pressure from their member-friends wouldn't hurt.—WJB

Inconsistency

RECENTLY THE *Chicago Tribune* published in tandem two articles originating in Washington. The first of these reported that the administration was lobbying for a bill to establish standby controls on the nation's soaring hospital costs. The article continued that the White House attached a very high

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priority to the bill as an important element in the President's drive against inflation.

The second article reported that a New Jersey Congressman wanted a new $75 million Veterans Administration hospital built in Camden. Just a short time before the White House, its Office of Management and the Budget and the General Accounting Office, had all been opposed to plans for building the 480-bed VA hospital at Camden. The VA had also agreed that they could do without the new hospital. Suddenly the Administration did an about face on the Camden project.

The proposed Camden hospital would be built only seven miles from a large VA hospital in Philadelphia that is now under-used, and not far from others in Wilmington, Delaware and Coatsville, Pennsylvania.

Wisconsin's Senator Proxmire, who is head of the Senate Appropriations Subcommittee in charge of VA funding, has been a consistent opponent to the Camden project. A Proxmire Subcommittee aide said that it seems ironic to spend $75-million on an unneeded hospital in order to cut hospital costs.

With a slight variation on an old theme, it only goes to show that in Washington there are more horse traders than horses.—VSF

Inevitable

WHEN THE STATE legislature overrode Acting Governor Schreiber's veto of the state law which required motorcycle riders to wear approved helmets, it was inevitable that motorcycle mortality would rise. This is exactly what happened. The State Department of Transportation reported that the Wisconsin death rate among motorcycle riders is 60 percent higher than for the same period last year.

The report indicated that 40 cyclists have died, 15 more than at the same time last year. At least 24 of this year's victims were not wearing crash helmets. By comparison, only two of the twenty-five 1977 victims were without helmets.

According to the *Wall Street Journal* statistics from other states are even worse. Accident studies in Colorado, Oklahoma, Kansas, and South Dakota, states that have repealed helmet-use laws, indicate that the chance of fatal head injury in an accident is four times greater for an unhelmeted motorcyclist than for a helmeted one. The National Highway Traffic Safety Administration reported that in Colorado where helmet use has declined from nearly 100% of the cyclists in 1976 to less than 60% in 1977 when that state's helmet-use law was repealed, the proportion of cycle accidents involving severe head injuries rose 260%. At the same time the rate of deaths climbed 57%.

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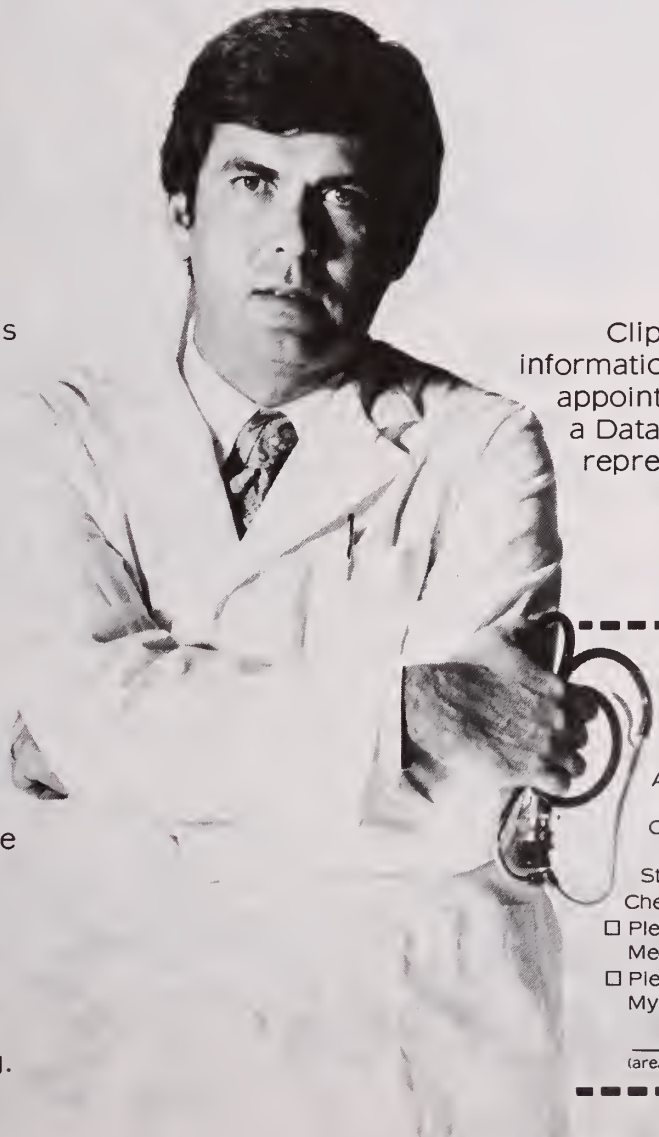

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The motorcycle enthusiasts protested that the helmets were hazardous because they restricted the field of vision and muffled the sound of other vehicle horns. Although this may be true to some extent, a motorcycle rider is so exposed and vulnerable that any protective device should be desirable.

Fractures will mend, and hide scraped off on the highway will resurface. However, head injuries are so often more disabling or lethal—and preventable.

It all goes to reinforce the old saw that you can lead a donkey to water but you can't make him drink.—VSF

Mother Russia

LAST YEAR A BRITISH physician was on a tourist trip to Kiev, capital of the Ukraine. One of the members of his tour group had a spontaneous miscarriage and the following are excerpts from his report to the *British Medical Journal* last November.

An ambulance was dispatched for the patient but the doctor in attendance seemed "remarkably disinterested" and ordered that the patient be dressed. On sitting up, she fainted but the dressing had to continue. No ambulance crew member would lift the patient and her husband and the British physician carried her down on a hotel chair to the ambulance. The ambulance was described as small and dirty and without blankets.

Upon arrival at the October Hospital in Kiev the patient's husband and the British physician had to carry the stretcher through a tortuous passage to a semi-basement room. After fifteen minutes of completing forms no further action was taken. A Russian physician who was smoking wandered in and out of the room and it was learned that he was the director. At this point the patient was in shock and the British physician asked if something could be done. Then she was prepped but left uncovered despite her shivering. No one appeared to take any interest in her blood

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loss or in examining the patient and no further blood pressure readings were taken.

The husband and British physician were told to take the patient up two stories to an "evacuation room." At this point the patient's blood pressure was 75/? and her husband was invited to leave. Without benefit of gloves, mask, cap, gown or towels, the patient was given a local anesthetic. This consisted of Novocaine drawn up from an open jar and the young lady doctor attempted a paracervical block with about 100 ml. This was a painful procedure and produced only minimal anesthesia. "During the evacuation, the doctor chatted to her assistant, and occasionally told the patient to be quiet. The latter nearly fainted with pain."

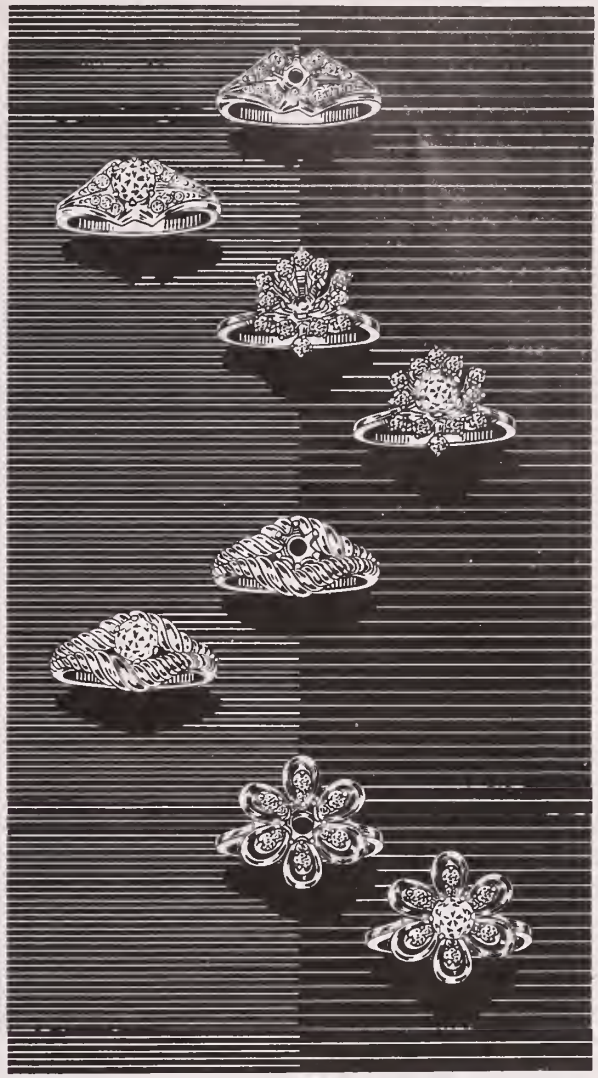
The patient was then taken to a small five-bed ward where a technician took blood by finger prick. The British physician was then brought an infusion set to put up. This consisted of a rubber tubing and two flasks. One was 500 ml in a sealed bottle said to be a plasma expander and the other was an open flask with a broken top filled from a jug and labeled "glucose and vitamins." The physician was given a very worn, metal and glass syringe and blunt needles, wrapped in brown paper.

After the infusion was finished the patient's blood pressure had risen to 90/70. Although the British physician requested further fluids to keep the drip open overnight, this was refused. He was told "we don't usually put up a drip—it was only because she was flying tomorrow. We never give blood for this condition." Fortunately she lost no more blood and her blood pressure was 100/70 by the next morning.

The British physician reported he was able to inspect the patient's toilets next to the evacuation room. There were two lavatories for 50 patients—one broken, neither having seats or paper. The floors were wet. Next to them was one bath with no plug. The only basin was unreachable for dirty and blood-stained linen piled in front. Some buckets and brooms occupied another damp corner. Fortunately the patient was given an enamel bedpan. She was not washed in the 18 hours she was in the hospital.

The next day she had some fever but the British doctor persuaded the director to let her out to the hotel where she was started on oral antibiotics from the British doctor's stock. Three days later she got home and was admitted to the hospital. Her hemoglobin was 7.4 gm per 100 ml and she was given a litre of blood. Four weeks later she was still on antibiotics for pelvic infection.

It would certainly be a revelation for those misguided individuals who are enchanted with all things socialistic to have an opportunity to receive some of their medical care under this glorious system.—VSF ■



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Laboratory tests and their costs

To the Editor: Would it be valuable for the practicing physician to *be sent a resumé* of all laboratory tests? *And their costs?* Personally, I do not know what the various costs of lab procedures that I order cost. While he is ordering "tests" and many patients think laboratory work (especially x-ray [to be curative]), he may find himself in a bind about defensive medicine—accurate diagnosis and his concept about the state of the art. (This would also simplify peer review.)

EDWARD C SCHMIDT, MD
2266 North Prospect Ave
May 6, 1978 Milwaukee, Wis 53202

EDITOR'S NOTE: Will a laboratory director please furnish Doctor Schmidt the information he requested?

Canadian plaudits for Wisconsin medicine

To Walter P Blount, MD: I have been very interested in your paper (Mellencamp DD, Blount WP, Anderson AJ: Milwaukee brace treatment of idiopathic scoliosis, *Clin Orthopaed Related Res* 126:47-57 [July-Aug] 1977) in this regard. Dr G R Viviani of the McMaster University Medical Centre and I have been discussing the pros and cons of setting up an ongoing scoliosis survey. I have been wondering whether the long-range outcome of treatment justifies the costs involved. I must say that Dr Viviani is enthusiastic about the screening of school children, and he reassures me that, in the long run, treatment keeps children from a life-threatening deformity.

Nevertheless, we are trying to build an evaluation component into our scoliosis screening so that we will know what the outcome of treating children will be and I think, because some children evade medical treatment, we might be able to establish comparisons between a treated and non-treated group. In any case, your paper reassures me and certainly would be a great help in setting up the protocol for an evaluation of our programme.

A I CUNNINGHAM, MD, DPH, DTMH (London)
Medical Officer of Health
Hamilton-Wentworth Regional Health Unit
PO Box 897, Hamilton, Ontario
Canada L8N 3P6

PS: Hamilton has benefitted a great deal from the medical work being done in Wisconsin. Our perinatal programme, set up by Dr Sinclair and our post-hospital psychiatric follow-up programme set up by Dr Dermer, have been modelled on something that has been going on in Wisconsin! Now we are into scoliosis and following your lead in this. Congratulations on a very enterprising medical community!—AIC

To Secretary Earl R Thayer: In response to the (above) letter I'll accept a small portion of his approbation but there are many others in the state who should take a bow for his remarks (in the PS). I can think of no one as knowledgeable as you as to who the others should be. The obvious thing is that Cunningham is impressed with Wisconsin, which is fine.

WALTER P BLOUNT, MD
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Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.
Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.
Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.
Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.
Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.
Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.
There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.
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As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.
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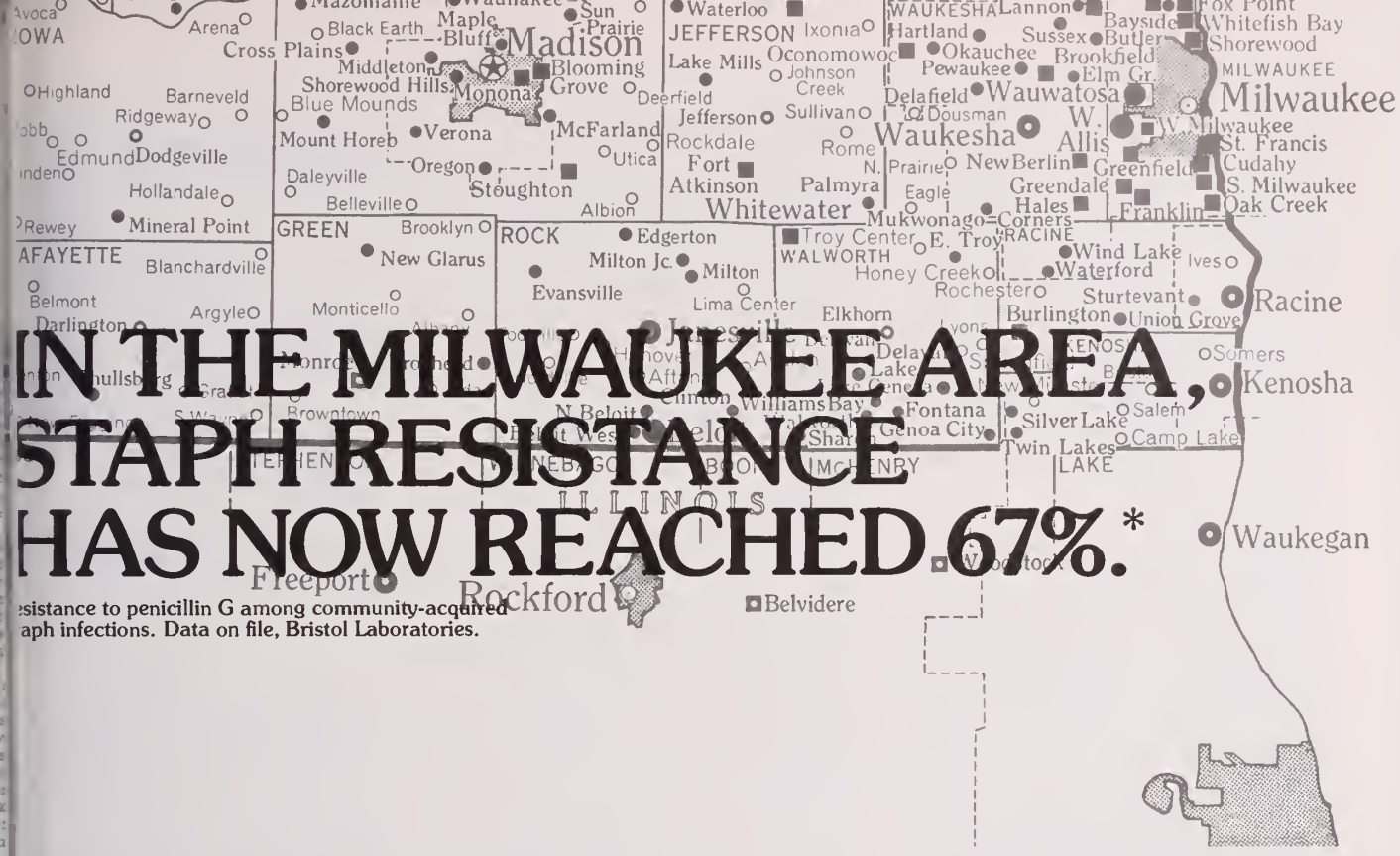

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†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of *in vitro* data is unknown.

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CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN AND ITS

COMMITTEE ON CANCER

OVER 450 PHYSICIANS and statisticians from the United States, Canada, South Africa, France, Scotland, Switzerland, and Italy recently attended the Eastern Cooperative Oncology Group (ECOG) meeting in Madison to discuss how cancer treatments can be improved. Dr Douglass McNeill of the Family Practice Clinic in Waukesha emphasized that the goal of physicians working with patients who have cancer should be "to learn how to help people with tumors rather than simply treat tumors in people."

Many of the protocols developed at this meeting use all of the common modalities— surgery, radiotherapy, chemotherapy, and immunotherapy. Some make use of new combinations of treatments or new drugs which are available for experimental purposes. Some improvements have been noted in the survival of patients suffering from breast, head and neck, lung, gastrointestinal, liver, and prostatic cancers, melanoma, leukemia, lymphomas, and Hodgkin's disease. Fewer cases of advanced breast cancer are being seen; more breast cancers are now being detected at earlier stages of growth before they have metastasized.

Survival is often related to the nutritional status of the cancer patient. Proper well-balanced nutrition influences the development and rate of cancer growth and the patient's response to chemotherapy. Unfortunately cancer patients often lose their desire to eat, and their sense of taste changes. Eating a good breakfast early in the day, the use of liquid diet supplements between regular meals, and feeding by naso-gastric tubes or intravenously in order to maintain a good nutritional status should be encouraged.

During one session physicians, who are members of the Wisconsin Oncology Group, learned about new treatment methods which will soon be available through the Radiation Oncology Division of the Wisconsin Clinical Cancer Center—hyperthermia and hypoxic cell radiation sensitizers.

Hyperthermia has long been recognized as a possible treatment modality for cancer, but few careful studies have been conducted. As early as 1866 some tumor regressions occurred in patients with high fevers due to infections. Coley in the 1890s treated several patients with a vaccine composed of an assortment of bacterial toxins causing a clinical infection and high fever which resulted in several dramatic regressions and some cures; however, there were serious toxic effects. At that time hyperthermia treatments were not practical because there was not an effective controllable method of heating a tumor. Recently there has been a renewed interest in hyperthermia using whole body hyperthermia, lasers, ultrasound, and microwaves.

Dr William Caldwell, Director of the Radiation Oncology Division, feels that diathermy units with a frequency of 434 MegaHertz will permit controlled, preferential heating of the tumor and better localization compared to whole body hyperthermia. Factors to be considered in the use of this modality are temperature to which the tumor and surrounding normal tissue are heated, time the tissue is maintained at the elevated temperature, method of administering the heat, number of hypoxic cells in the tumor, differential absorption by various adjacent tissues, and depth of the tumor.

Dr Caldwell and Dr Michael Kademian, also of the Radiation Therapy Center, plan to use modest amounts of heat (40-41 C) for approximately 20 minutes before and after irradiation with no more than a third of the patient being warmed. External heating using microwaves will permit preferential heating of tumors (with a poor blood flow), with the circulatory system cooling the normal tissues to a greater extent, thereby avoiding serious normal tissue effects. Hyperthermia alone may have limited effectiveness, but there may be a synergistic effect on tumor control when hyperthermia is used in conjunction with radiation.

At first patients with advanced urinary bladder tumors, cervical cancer (III_B and IV_A) still confined to the pelvis, head and neck cancers, glioblastomas, and nonresectable or partially resectable pancreatic and stomach cancers will be treated. However, Dr Kademian feels that ultimately the role of hyperthermia will be to treat small tumors (2-4 cm), but treatment of larger tumors will be necessary for the initial studies. Experimental data indicate that heat will decrease the amount of radiation required and will control the disease better than radiation alone with less morbidity and better functional results. Because the morbidity of treatment of small tumors will be minimal patients will hopefully be persuaded to seek treatment earlier when there is more chance of successful treatment and less chance of morbidity. He does not believe that this treatment will salvage all patients but hopes that it will enable conventional local treatments to be better tolerated and cure rates increased for patients who have localized tumors.

Another exciting development in radiation therapy is the use of hypoxic cell radiation sensitizers which act like oxygen but are not metabolized in the same way. Cells tend to be radioresistant when they do not have a good oxygen supply. The most logical radiation sensitizer would be oxygen. This can be done by placing the patient in a hyperbaric oxygen tank that drives oxygen into plasma; however, such treatment is dangerous, expensive, and has only shown marginal, if any, improvement in treatment effectiveness. The other possibility is to use hypoxic cell sensitizers or chemicals which act like oxygen, are not metabolized, penetrate into the hypoxic cells and have a radiation sensitizing effect. These agents penetrate into the hypoxic cells to a level about 90% that in plasma. Their primary action is as a radiation sensitizer, but they also form cytotoxic metabolites through anaerobic reduction. This effect is most pronounced at the site of production, in the hypoxic areas. Unfortunately, these agents—of which metronidazole (Flagyl®) and misonidazole are the clinical prototypes—cause severe nausea and vomiting at the time of administration and are neurotoxic. Dr Caldwell hopes to use these drugs in conjunction with radiation (and possibly hyperthermia) to treat glioblastomas and advanced head and neck cancers as pilot studies of

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Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Supported by NCI Grant No. 5 R18-CA-16405-03.

the Radiation Therapy Oncology Group (RTOG).

The sharing of concerns for cancer patients between physicians from around the world in groups such as ECOG, RTOG, and WOG and discussions of how cancer can best be prevented, diagnosed early, and treated should help assure cancer patients entered into protocols and the involved physicians of those protocols that they are receiving excellent, rational, as well as ethically sound, treatment.

You may contact Dr Paul P Carbone, the chairman of ECOG, at the Wisconsin Clinical Cancer Center for further information about protocols used to treat various types of cancer or Dr William Caldwell or Dr Michael Kademian for information about hyperthermia, hypoxic cell radiation sensitizers, and RTOG protocols.

—Dorothy J Buchanan-Davidson, PhD
Science Writer

Mark your calendar

September 29: *Wisconsin Oncology Group,* at the Center for Health Sciences in Madison. Contact Dr R O Johnson at the Wisconsin Clinical Cancer Center for details.

September 30: *Fall Cancer Conference,* at the University of Wisconsin. Contact Millicent Baltus of the American Cancer Society, Wisconsin Division, for details. ■

DIALOGUE

Ralph Andreano predicts physician's role in state health management

Attempts to reduce health-care expenditures through internal regulation of physicians' incomes are "fruitless" and costly endeavors, ultimately jeopardizing cost-conscious practices in state health management, according to former Division of Health administrator Ralph Andreano, PhD.

Professor Andreano, who left the academic community for a two-year stint in health administration, was an invited guest of the Dane County Medical Society at its June 13 meeting at SMS headquarters in Madison.

His topic, "Reflections of an Ex-Bureaucrat," gave Andreano an uninhibited opportunity to express his views on medical and political issues encountered during his controversial two-year tenure in state government.

Target income

Concerning physician income regulation, Andreano contends that physicians are deeply imbedded within traditional, widely accepted methods of medical practice; and, therefore, (physicians) "can defeat any regulation that you put in front of them which tells them what they can or can not do."

He believes that physicians practice medicine to attain a "target income," or a preconceived perception of the societal value and subsequent income level appropriate for professional medical services. Professor Andreano insists that the recognition and identification of that range of target income, rather than internal regulation, is the key to efficient state health management. "We should recognize that physicians work for a target income, see if one can identify what that income might be, and leave you (physicians) alone. If you're left alone, you'd probably turn out to be much more conscious of the clinical cost-effectiveness of your actions because you will not feel that your practice or profession is jeopardized," Andreano told the Dane County physicians.

Professor Andreano cited the results of the historic economic stabilization period (wage and price controls) to support his income regulation proposal. "We had price controls in the economic stabilization period but that didn't dampen your (physicians) amount of expenditures, income, or amount of total health-care expenditures; you simply and rationally shifted where you did your business."

Andreano elaborated on the prospects of efficient health management by incorporating a unified reimbursement plan with the physician's target income. "Wouldn't it be nice for physicians," he said, "if no matter whatever insurance an individual has, the method of reimbursement was identical . . . We should take Title 19 (Medicaid), the State Employe Group Health Contract, and possibly Medicare (Title 18) and form a single insurance pool with a common set of benefits and a common reimbursement system. If we were able to get such a large, gigantic insurance pool, and add as a parameter to let physicians earn their target incomes, that would have a major impact on total health-care expenditures in the state."

Andreano said he would like to see an HMP (health maintenance plan) for Medicaid people. He conceded, however, that

such a proposal would require legislation and fee negotiation.

Urges SMS support

Professor Andreano expressed a personally long-standing proposal to divide the current Department of Health and Social Services into three separate agencies: the Department of Corrections, Department of Health, and the Department of Income Maintenance.

Ralph Andreano, PhD . . .
professor of economics at the University of Wisconsin-Madison since 1965; holds degrees in economics from Drury College, Washington University, and Northwestern University; has taught at Earlham College, Harvard University, and the Brookings Institute; and has been the chief economist for the World Health Organization's Division of Strengthening Health Services.

The former health administrator provided three reasons to justify the proposed reorganization: "What has happened in the past 10 years is that the State's regulatory posture, regarding the health system, has grown enormously at both federal and state government levels. The perception of a health system is not in just public or government programs but an entire health system."

"The health system, while it does have some interfaces with the rest of the human service agencies inside the Department of Health and Social Services (DHSS), is far bigger and has far broader interfaces that you can't really be forced into a situation of trying to integrate it with other human service programs. And to force that integration will either sacrifice some of the State's regulatory roles or some of the gains made in state planning," Andreano said.

"The second reason why I feel a single overhead human service agency, such as the DHSS, is inefficient is that I don't think there are scale economies in a human service agency. It is more inefficient to have a single overhead agency and less cost-effective than having three separate agencies (Health, Corrections, and Income Maintenance). Perpetuation of more bureaucratic inefficiencies would probably not result from more bureaucratic agencies because some brakes can be put on that by the Legislature and the executive branch of government. This situation makes it possible for direct public and political response to be made if someone doesn't like what's happening."

Andreano added that "health is so bloody important that having to fight for budgetary priorities inside an agency where five other programs are fighting for budgetary priorities degenerates the role of the health-care system in the state. Health is the number one industry in the state and yet it is treated as a second or third class priority. I can only hope the State Medical Society will give serious consideration to supporting legislation to create a separate Department of Health."

(The SMS unofficially has expressed its preference for separation of the Division of Health from DHSS, with creation of a Department of Health.)

Many frustrations

Andreano alluded to some of the frustrations he experienced in state government: How to get significant political changes in government quickly. He had no power to appoint anyone. His Division was dependent on the Civil Service Commission to obtain staff and retain it. He had high aspirations, but meager accomplishments. Rules and regulations were paralyzing. He said the bureaucratic system is inflexible and too slow-moving. In a volatile area such as health, slow change is dangerous. There was no capability for innovation, he lamented.

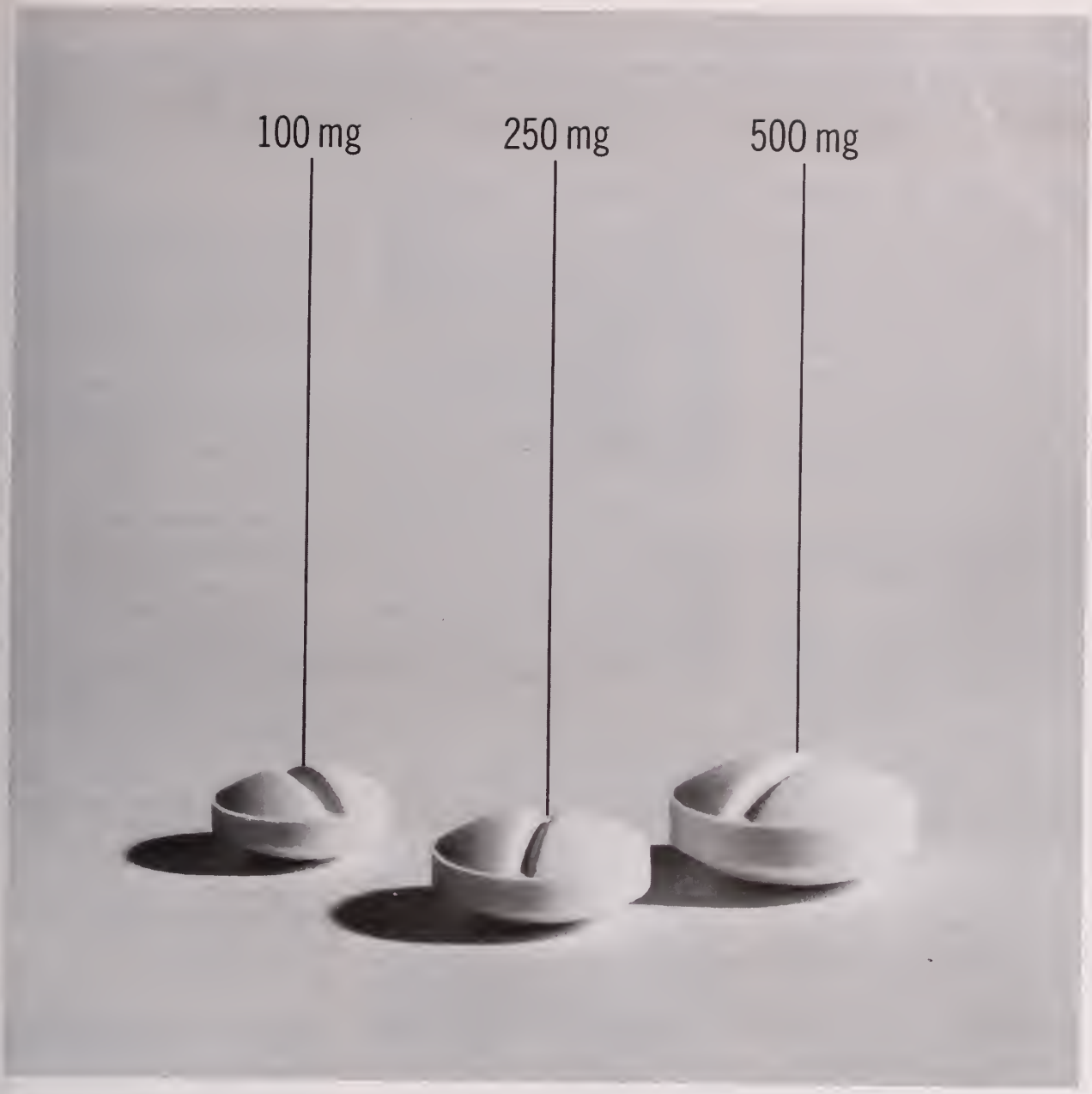
Andreano criticized the State of Wisconsin and its citizenry for being "too smug about the quality of our services. For the dollar spent, we have nothing to be smug about."

No regrets

Professor Andreano concluded his remarks by praising the present health administration and expressing "no regrets" over his two-year political tenure.

"The Wisconsin idea," he concluded, "where university professors do what I did is good . . . if those ideas that I introduced are not valid, they will be dropped. There is merit in the rapid infusion of new blood into government—that's the only way to expose new ideas."

THE JOURNAL offers *Dialogue* as an opportunity for physicians and others to express themselves in matters germaine to medicine. ■



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SMS Council passes T-19 contract resolution

The decision to sign or not to sign the Medical Assistance Contract rests with the individual physician, said the State Medical Society of Wisconsin's Council in adopting a resolution at its June 3 meeting on the Medical Assistance Contract, future contracts, and the Medical Assistance Super-Rule.

At that meeting the Council also:

- Agreed to conduct an opinion poll of all Wisconsin physicians on whether unified membership should be retained in Wisconsin.
- Agreed to continue SMS participation with WHCRI and DHSS in a joint study on the medical necessity for surgery in Wisconsin.
- Authorized a $5,000 contribution to a "start-up" fund for a statewide, nonmembership peer review foundation in Wisconsin, with anticipation of additional funding from the Blue Plans, commercial insurance carriers, and the Wisconsin Hospital Association. The Council also received a preliminary report from the Steering Committee on Peer Review which outlined goals, objectives, and Board membership of the foundation.
- Expressed no objection to Professional Standards Review Organizations (PSROs) handling second opinion surgery referrals for Title 18 and Title 19 programs if they wish to do so, but expressed concern with the necessity for the program and the methods for the program and the methods for selecting the "consultant" physicians.
- Established the dues structure for a new out-of-state SMS membership category at 30 percent of the regular membership dues. This would permit SMS members who move out of state to retain certain insurance or IRA coverages.
- Approved establishment of practice management workshops for physicians next September in Eau Claire, Green Bay, and Madison.
- Opposed a proposal by DHSS to conduct independent medical review of nursing homes through state-employed physicians rather than privately practicing physicians. ■

Doctor Collentine elected to Council on Medical Service

George E Collentine, MD, Milwaukee was chosen to serve on the AMA Council on Medical Service June 22 at the 1978 AMA Annual Meeting in St Louis.

Doctor Collentine has served as a delegate to the AMA since 1970, as an alternate delegate from 1960-70, and as president of the Medical Society of Milwaukee County in 1968.

He also has been active in several SMS commissions and committees including the Committee on the Cost and Evaluation of Medical Care and the Wisconsin Committee implementing the AMA/AHA Voluntary Effort for hospital cost containment. ■

SMS welcomes new staff members

The State Medical Society recently added new staffers to its Physicians Alliance and Quality Care Divisions. Joining the Physicians Alliance staff are: Paul Jacobson of Eau Claire, the new field consultant to Northwestern Wisconsin; and Richard Reas of Grafton, research assistant for the Division. New to the Quality Care Division is Neal Neuberger of Madison, who is working as the health planning analyst for the Division. ■

Dr Paul Mason receives Civic Leadership Award

Paul B Mason, MD of Sheboygan was the recipient of the Civic Leadership Award of the State Medical Society of Wisconsin June 13. Presented to Doctor Mason by Walter F Smejkal, MD at a special meeting of the Sheboygan County Medical Society, the award is given on occasion to a physician who has shown outstanding dedication not only to the progress of medicine but also to involvement in the democratic process. Doctor Mason's award marks the seventh presentation of the Society's Civic Leadership Award.

Doctor Mason is a native of Chippewa Falls, Wisconsin and received his medical degree from Northwestern University Medical School in 1931. He interned at Passavant Hospital in Chicago, and served a three-year residency at the Mayo Clinic in Rochester, Minnesota before joining the Sheboygan Clinic in January 1936. An internist, Doctor Mason was president of the Clinic from 1955 to 1972; and it was noted at a testimonial given in his honor in 1973 that Doctor Mason had seen at least 161,573 patients during his 36 years at the Sheboygan Clinic.

Doctor Mason has been active in a leadership role with the State Medical Society and is a past president of the Sheboygan County Medical Society. For many years Doctor Mason served on the WPS Commission of the State Medical Society. He also has served on the Society's Commission on Peer Review and as president of the Wisconsin Health Care Review, Inc. ■

SMS cuts ties with WPS

The State Medical Society of Wisconsin, June 3, completed the process of separating from Wisconsin Physicians Service at a WPS corporate membership meeting.

The 27-member SMS Council—which also served as corporate membership for WPS—approved revised articles of incorporation removing that tie, and the Council's authority to elect the WPS Board of Directors. Last June WPS was incorporated separately from the Society to comply with a new state law. The June 3 action cut the last formal link between the health insurance function and the Society. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.36 as of May 31, 1978. ■

SMS with AMA to sponsor Practice Management seminar in September

In response to a number of requests over the past two years, the SMS Committee on Economic Medicine—working in conjunction with the AMA and Wisconsin experts in the fields of law, accounting, and insurance—has planned a two-day program on Practice Management to be presented in September at three locations: Eau Claire, Green Bay, and Madison.

The program is designed to provide an unusual educational opportunity for solo practitioners and small group practices. Speakers are recognized authorities in their fields and the two-day span allows adequate time to properly cover each subject. A question and answer period will follow each discussion session.

In order to promote a dialogue between speakers and participants, attendance will be limited to 30 participants each day on a first-come, first-serve basis, so early reservations are advisable. Details on time, place, and subject matter for the seminar will be given in a brochure being mailed to members.

The Practice Management seminar has been approved for Category 1 CME credit, on a one-credit for one-hour basis, by the AMA. Attendance at the entire seminar will provide a total of 12 CME credits. ■

THE SMS AUXILIARY's chairman of the Wisconsin AMA-ERF, Mrs Lloyd Jenk of Milwaukee, presents the Foundation's contributions to Leonard Cronkhite Jr, MD (above), president of the Medical College of Wisconsin, Milwaukee, and Bernard Nelson, MD (below), acting dean of the University of Wisconsin-Madison Medical School.

AMA-ERF presents grants to state's medical schools

Wisconsin's two medical schools have received $18,831 in grants from the American Medical Association's Education and Research Foundation (AMA-ERF).

The money was raised by medical society auxiliaries throughout the country and includes contributions as the result of fund-raising events and contributions from physicians, foundations, and industries.

The Auxiliary of the State Medical Society of Wisconsin presented a check for $9,853 to the Medical College of Wisconsin and one for $8,978 to the University of Wisconsin Medical School.

The AMA-ERF solicits funds both for gifts to the nation's 112 AMA-approved medical schools and for its Medical Education Loan Guarantee Program. Through the loan guarantee program the AMA-ERF maintains a loan security fund which allows participating banks to lend medical students $12.50 for every $1.00 held in the fund.

The funds are unrestricted; the schools may use the money to best suit their needs.

AMA-ERF, a nonprofit organization, was established to assist medical colleges in providing quality education and research and to aid students with the burden of financing the high cost of a medical education. Approximately two-thirds of AMA-ERF's income is derived from physicians and AMA auxiliaries. ■

Dr Dessloch presented Council Award

Eli Max Dessloch, MD of Prairie du Chien received the Council Award of the State Medical Society at the Society's June 3 Council Meeting in Madison.

The Council grants the award "only upon occasion to physicians who have served with outstanding distinction the science of medicine, their fellow physicians, and public."

Doctor Dessloch has guided the Wisconsin Physicians Service (WPS) from its infancy in 1946 to the present time. He served as a member of the first WPS Operating Committee from 1946 to 1949 and that year was named Chairman of the Directing Board of WPS and later Chairman of the WPS Commission. In his role as Chairman of the WPS Commission, he was an innovator of prepaid health insurance.

His practice located just one block from the Fort Crawford Military Hospital at the Museum of Medical Progress in Prairie du Chien, Doctor Dessloch has been a driving force in developing the complex. In 1943 he headed a group of Crawford County physicians who worked to restore the Fort Crawford Hospital as a museum.

He was a member of the Board of Trustees of the Society's Charitable, Educational and Scientific Foundation which has operated the museum since 1960. He became a member of the Permanent Commission of the Museum of Medical Progress in 1960, and in 1973 he received the Foundation's Award of Merit in appreciation for his long work on behalf of the museum.

Doctor Dessloch served on the Council of the State Medical Society from 1947 to 1965 and in 1971 he was named an Alternate Delegate to the American Medical Association.

A graduate of the University of Wisconsin Medical School in 1935, he interned at Alameda County Hospital in Oakland, California. Specializing in general practice and orthopedics he practiced in Prairie du Chien from 1939 to 1978. ■

SMS President appeals to Carter for Medicaid red tape relief

In response to continuing cost inflating state and federal directives to Wisconsin physicians concerning their treatment of Medicare and Medicaid patients, SMS President Jules D Levin, MD sent a telegram to President Carter July 7.

The recent floods in Wisconsin and the subsequent declaration of disaster areas sparked the analogous slant of the telegram which follows:

"The State Medical Society of Wisconsin urgently appeals to you to declare Wisconsin a Medicaid disaster area, thus hopefully making it eligible for federal and state emergency regulation relief.

"The flood of federal and state rules affecting Medicaid in the past year is drowning out the participation of physicians, their offices are mired in paperwork, and thousands of Medicaid recipients may be driven from their regular doctor's care.

"Still worse, another two inches of regulations are forecast for issuance this month (July) in the form of "super rule," a label attached by Wisconsin Department of Health and Social Services officials. In addition, a federal laboratory billing regulation will be implemented which alone is expected to do about one million dollars 'damage' per year in Wisconsin alone by way of increased costs to physicians' offices, red tape paperwork, and delays and errors in processing Medicaid claims.

"Secretary of HEW Califano, a member of your cabinet, has steadfastly refused all Wisconsin Department of Health and Social Services appeals for relief from this impossible and unfeasible regulation known as Action Transmittal 77-35. He appears to be thumbing his nose at your personal pledges and directives for cost containment, less red tape, and more simplicity in government. Mr President, we pray for your intervention to suspend implementation of AT 77-35 and to halt the outpouring of rules and administrative actions in which the Wisconsin Medicaid program is currently wallowing."

A copy of the telegram also was sent to Wisconsin's Congressmen, Governor Schreiber, and Donald Percy, secretary of the Wisconsin Department of Health and Social Services.

Kenneth M Viste Jr, MD (left), chairman of the SMS Physicians Alliance Commission, presents Acting Governor Martin Schreiber with a certificate of commendation (see story below). (Staff photo by Ken Opin)

Doctor Levin and John P Mullooly, MD, SMS councilor and president-elect of the Wisconsin Society of Internal Medicine, expect the President to respond favorably to help Wisconsin physicians reduce paperwork and increased processing costs to Wisconsin's medical patients. Both physicians hope the AMA and other state medical societies will join Wisconsin in asking the President to work with all doctors in this cost-containment effort. ■

SMS sponsors I C System, Inc

At its meeting on June 3, the Council of the State Medical Society voted to sponsor the debt collection service offered by the I C System, Inc, as a benefit for the physicians of Wisconsin.

Physicians should be aware of the complexities and hazards of legal requirements governing debt collection practices. These regulations affect both debt collection services and those members of the physician's own staff who may be working with accounts receivable.

I C System, Inc, is running a full page ad explaining the system in this issue of the Journal. See page 33 for details. ■

Physicians Alliance Commission meets with Governor

The Physicians Alliance Commission, June 16, presented Acting Gov Martin Schreiber with a certificate recognizing his veto of a bill earlier this year which would have mandated the inclusion of chiropractic in all health insurance policies sold in Wisconsin.

At that meeting the Acting Governor took the opportunity to discuss with physicians various current health-care issues.

"The expenditures for Medicare and Medicaid continue to increase in Wisconsin at an alarming rate," Schreiber said. "In fact, the single most costly program in Wisconsin is the nursing home program, which costs over $500 million a year. Of this $500 million, only nine percent goes to physicians," Schreiber said.

"Every year 10 to 30 percent of the Medicaid expenditures in Wisconsin are lost due to lack of proper control," he commented. Because of experience such as this with the Medicaid program, Schreiber said he is "disillusioned" with the concept of national health insurance, and only would favor some form of catastrophic health insurance program.

The Acting Governor also used the meeting to make a plug for his wellness revolution concept and said that "the best way to invest in the health of Wisconsin people is to put more effort into prevention and wellness programs." ■

COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

April 12, 1978—Milwaukee

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 1:40 pm on Wednesday, April 12, 1978, at the Marc Plaza Hotel in Milwaukee.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Doctors Boulanger, Schmidt, Foley, Nielsen, Bruhn, Steffen, LaBissoniere, Mullooly, Eisenberg, Crowley, Tuftee, Waterhouse, Natoli, Kief, Lewis, Peters, Flaherty, Smejkal, Barrette, Picard, Larsen, Levin, Motzel, and Taebel.

Others present (part or entire): Doctors Derus, Twelmeyer, Collentine, Williams, Dettmann, Scott, Behnke, Kenneth Johnson, Jordon Frank, Viste, Alan Nelson (Utah), Latorraca; Mmes Mielke, Lyons and Smigielski; Messrs Thayer, Maroney, Johnson, Jensen, Nelson, LaBissoniere, Wood, Wendle, Brozek, Mendelson, Brown, McIntyre, Bowers; Mmes Bartel, Upton, Wiersum, Riley; Miss Pyre.

2. Approval of Minutes of February 4, 1978

Minutes of the last meeting were approved on motion of Doctors Eisenberg-Picard, carried.

3. Report of Auxiliary President

Mrs John E Mielke, Appleton, reported on Auxiliary activities during her term as president, and distributed copy of the convention folder containing committee and county auxiliary annual reports.

4. Report of Treasurer

In the absence of Doctor Nordby, the annual report of the treasurer on the Society's general fund was discussed by Doctor Edwards.

On motion of Doctors Smejkal-Schmidt, carried, the report was received by the Council.

5. Report of Finance Committee

A. Employees' Pension Plan

Doctor Edwards reported for information on the managing committee's review of investments and the actuary's valuation of the plan as of the date WPS commenced its own payroll system. The committee established the employer contribution and interest rate on employee accumulation accounts for 1978.

B. Finance Committee recommendations

(1) Legal fees re WPS separate incorporation

The committee has requested that Doctors Nordby and Edwards seek a meeting with representatives of the WPS Board to negotiate a settlement of the $6,532 in legal fees related to separate incorporation of WPS.

(2) Audit reports

Copy of the December 31, 1977, report on the Society by the CPA consulting firm was distributed to Council members along with the treasurer's report. The committee intends further study at its next meeting of audit reports on subsidiaries.

On motion of Doctors Edwards-Picard, carried, the above-mentioned reports were received by the Council.

(3) Budget-expense report and special appropriations

It was reported that the 1977 budget was underexpended by $2,033, and that 1978 expenses are under budget through February. The number of members with dues paid in the first quarter is 317 more than in 1977, and 28 more new members have been added to the rolls.

The committee reviewed the request from the CES Foundation for subsidy from the dues structure to enable the opening of the Museum of Medical Progress this summer. It recommended subsidy of an operating loss estimated at $9,510 to open only the Fort Crawford Hospital and administration building from May 1 to Labor Day, five days a week.

On motion of Doctors Edwards-Schmidt, carried, this was approved by the Council.

The committee also discussed the request for additional funding for televising the 1978 Work Week of Health on the Wisconsin Public Television Network. It recommended that the Council approve funding in excess of the $2,250 already budgeted, up to an additional $7,750, but with the understanding that every effort will be made to secure these funds from outside sources.

On motion of Doctors Edwards-Picard, carried, this recommendation was approved by the Council.

(4) Dues for 1979

After lengthy discussion and consideration of projected reserve figures if there were no dues increase, the committee proposed that the Council recommend to the House of Delegates that 1979 regular member dues be increased by $20, which is between 6.5 and 7% of current dues. The CPI increase from 1975-76 was 5.8%, from 1976-77, 6.5%, and from 1975-77, 12.6%. It is believed that a $20 increase in 1979 and similar adjustments in succeeding years will continue the Society's reserves at about two and one-half months of operating costs.

On motion of Doctors Edwards-Foley, carried, this recommendation was approved by the Council.

6. Report of Committee on Economic Medicine

A. Proposed Bylaw creating nonresident membership category

On motion of Doctors Picard-Mullooly, carried, the Council recommended House of Delegates approval of a Bylaw amendment creating a nonresident membership category which would permit a physician who, while in dues-paid status, transfers his/her practice out of the state to maintain affiliation with the Society and continue certain membership benefits. [The wording of the Bylaw may be found in the report of House actions in the May 1978 WMJ and in the next printing of the Constitution and Bylaws.]

B. Keogh Plan fund transfers

On motion of Doctors Tuftee-Mullooly, carried, the Council authorized Seefurth-McGiveran to transfer Prudential-Keogh Plan funds, at the request of individual physicians, to banks or savings and loan institutions without SMS official approval in each instance.

C. Membership service-benefit programs

(1) Chapter 180 for-profit corporation

On motion of Doctors Mullooly-Edwards, carried, the Council approved the recommendation that membership service-benefit programs be accomplished by the Society under a Chapter 180 for-profit corporation structure.

(2) New service-benefit programs

(a) Debt collection service

On motion of Doctors Mullooly-Eisenberg, carried, the Council approved the recommendation that the Society endorse a debt collection service in order to assure both the patient and the physician that such activities are conducted in a fair, ethical and professional manner, and the further recommendation that IC System, Inc, of St Paul, be endorsed at this time as the organization with which to enter into a contract.

(b) Single insurance package

On motion of Doctors Mullooly-Waterhouse, carried, the Council approved the recommendation that Seefurth-McGiveran review and report back to the committee on the feasibility of a single package-one carrier program for all of the Society's insurance plans for members.

(c) WPS HEALTH INSURANCE

The committee reported its intention to approach WPS on broadening the eligibility requirements for health care and major medical insurance to include coverage for member physicians and their staffs.

(d) PRACTICE MANAGEMENT SEMINARS

On motion of Doctors Mullooly-Nielsen, carried, the Council approved the recommendation that the Society enter into an agreement with the AMA for the presentation of a seminar on practice management in three different Wisconsin cities within a one week period in September or October.

Doctor Eisenberg suggested that residents and nonmembers be encouraged to attend at an appropriate rate.

7. Ad Hoc Committee on Quality Care Activities

The committee presented for Council approval a protocol manual on peer review for use by the Commission on Peer Review and other Society committees as necessary. It was noted that the Council had previously approved a protocol for the Commission on Mediation and Professional Ethics.

There was discussion of a section on financial support which read as follows: "There is a recognized need for compensation to Commission members for expenses incurred in connection with review activities, including on-site review. They should be reimbursed by a third party payer or the Society for travel expenses, for cost of food and lodging, and for incidental costs related to collection and analysis of data. Consideration should be given to a method for charging third parties having program responsibility on an equitable basis, and in amounts sufficient to fund review activities. By established policy, the Commission does not expect compensation for travel to, or time spent during Commission meetings."

It was explained that the intent was that third party payers would be billed by the Society for review services, which in turn would reimburse physicians for review time. It is not intended that Commission members routinely be paid for meeting attendance. Nevertheless, the ad hoc committee was asked to consider the fiscal impact of expanded activity of the Commission on Peer Review for which there may be no third party funding.

On motion of Doctors Lewis-Levin, the protocol manual was approved with deletion (moved by Doctors Foley-Edwards) of the words "or the Society" in the section quoted above.

8. Physicians Alliance Commission

Doctor Viste summarized a written report on PAC activities distributed to the Council. Mr Jensen gave an update on the status of the contract and super-rule.

Attorney John Bowers reported on items under negotiation with DHSS relative to the contract, and advised that the question of whether a physician or any other provider will sign the contract should remain an individual choice. He urged that the Council authorize continuing negotiations with the Department to resolve as best they can be the differences over the content of the provider contract.

On motion of Doctors Eisenberg-Steffen, carried, the Council reaffirmed support of the negotiating team on behalf of physicians in this issue.

9. Private Patient Peer Review in Wisconsin

Dr Alan Nelson of Salt Lake City described the organizational structure of UPRO, the Utah Foundation/PSRO.

Doctors Lewis-Picard moved that the Council establish a new committee to explore the possibility of going in the direction of Utah, with the State Medical Society being the key organization.

There was lengthy discussion, with expressions requested from Doctors Johnson (FMCE) and Scott (WisPRO). Doctor Haskins presented a preliminary proposal for a statewide private peer review organization. Also reviewed were February 20 minutes of the special committee on peer review chaired by Doctor Larsen.

After discussion, on motion of Doctors Waterhouse-Flaherty, carried, the Council requested that the chair appoint a committee of councilors to meet with whomever they chose and report back on Saturday, April 15.

On motion of Doctors Motzel-Levin, carried, the Council recommended to the House of Delegates reference committee that it take no action on that portion of Council Report T dealing with peer review.

10. Adjournment

The meeting adjourned at 5:55 pm.

EARL R THAYER
Secretary

Approved June 3, 1978
PAUL S HASKINS, MD
Chairman

Minutes of Special Council Meeting April 15, 1978—Milwaukee

1. Call to Order and Roll Call

The meeting was called to order at 7:05 am on Saturday, April 15, 1978, at the Marc Plaza Hotel. All voting members were present except Doctors Foley, Schmidt, and Peters.

Others present: Doctors Twelmeyer, Collentine, Scott, HJKief, Stuff, and Behnke; Messrs Thayer, Maroney, Jensen, Wendle, Brown; Miss Pyre.

2. Ad Hoc Committee on Peer Review

The meeting was called to receive a report from the committee appointed pursuant to Council action on April 12, which was presented by Doctor LaBissoniere, chairman.

Doctors Kief-Taebel moved acceptance of the report.

The third paragraph on page 2 read as follows: "Under these provisions the existence of WHCRI as presently constituted would no longer be necessary, and WisPRO as presently designed would be subject to reorganization. Such reorganization would be modeled closely after that of UPRO (Utah)."

On motion of Doctors Waterhouse-Picard, carried, this was amended to read as follows:

"After WisPRO, as presently designed, is reorganized similar to the UPRO (Utah) organization with direct linkage with the State Medical Society, the medical review function of WHCRI will no longer be necessary."

On motion of Doctors Waterhouse-Picard, carried, the Council approved minor rearrangement of words in the fourth paragraph on page 2, to read as follows:

"In the interests of cohesiveness and effectiveness of the medical profession of the State of Wisconsin and in consideration of the needs of the patient public, the Foundation would be statewide with the hopeful anticipation of the future association of the Foundation for Medical Care Evaluation and therefore ultimately the inclusion of all peer review in the State of Wisconsin."

The motion to accept the report as amended carried. [The full report, as presented to and accepted by the House of Delegates at its third session on April 15, may be found in the summary of House actions in the May 1978 WMJ.]

It was understood that any fiscal impact on the Society would be brought back to the Council by the steering committee before any commitment is made.

3. Adjournment

The meeting adjourned at 7:35 am.

EARL R THAYER
Secretary

Approved June 3, 1978
PAUL S HASKINS, MD
Chairman

Council Minutes

April 15, 1978—Milwaukee

1. Call to Order and Roll Call

The meeting was called to order at 10:35 am on Saturday, April 15, at the Marc Plaza Hotel.

Voting members present: Chairman Haskins; Vice-chairman Edwards; Doctors Boulanger, Foley, Bruhn, Steffen, LaBissoniere, Mullooly, Eisenberg, Crowley, Tuftee, Waterhouse, Natoli, Kief, Lewis, Peters, Flaherty, Smejkal, Barrette, Jauquet, Larsen, Levin, Motzel, and Taebel.

Others present: Doctors Twelmeyer, Scott, HJKief, Stuff, Williamson, Picard; Messrs Thayer, Maroney, Johnson, Jensen, LaBissoniere, Brown; Miss Pyre.

2. Oath of Office

The oath of office was administered by the chairman to J M Jauquet, MD, Ashland, new councilor from the eighth district.

3. Elections

By separate motion duly made, seconded and carried, the following elections took place:

Council Chairman: Paul S Haskins, MD
Vice-chairman: Timothy T Flaherty, MD
Society treasurer: Eugene J Nordby, MD
Assistant treasurers: A A Quisling, MD, and H Kent Tenney, MD
Secretary and general manager: Earl R Thayer
Medical editor, *Wisconsin Medical Journal* (two-year-term): Victor S Falk, Jr, MD
Editorial director: Wayne J Boulanger, MD
Editorial associates: John P Mullooly, MD
T H McDonell, MD
Philip J Dougherty, MD
Raymond A McCormick MD
Brenton H Field, Jr, MD

4. Appointment of Consultants

Robert B Murphy was reappointed Society legal counsel, and Donald E Gill & Co as independent CPA consultants.

5. Report of Executive Committee

As unfinished business from the April 12 meeting, Doctor Levin reviewed minutes of the committee's March 31 meeting which were provided the Council. Action was taken as follows:

A. Requests of Department of Justice

The Council was informed of the status of the Department's requests for information from the State and county societies which is to be used to determine whether there is restraint of trade or price fixing.

On motion of Doctors Natoli-Edwards, carried, staff was directed to assemble sufficient information and be prepared to promulgate the Society's views of the matter through distribution to the press, public, and legislators, both state and federal.

B. Title 18 Peer Review

On information that WisPRO planned to communicate with HEW its willingness to assume the peer review function for Title 18 (Medicare) which has been handled by the SMS Commission on Peer Review, the Executive Committee had directed that a communication be sent to the WisPRO chairman, Doctor Scott, asking reconsideration and suggesting it inform HEW that this review is being appropriately performed by the Society's commission.

Doctor Scott informed the Council that the communication had not been sent to HEW, and that the Executive Committee's request would be considered by the WisPRO board in May.

Doctor Kief requested that this matter be referred for handling by the Steering Committee on Peer Review.

C. Nurse Practitioner (Joint Practice vs Independent Nurse Practice)

The Council reviewed a paper prepared by Assistant Secretary Maroney on the "current status of the nurse practitioner" in Wisconsin. It included a position statement of the Joint Practice Committee for a hearing on the independent nurse practitioner scheduled by the Medical Examining Board for May 6 (subsequently cancelled), approved by the Executive Committee on March 31, which incorporated by reference the previously adopted statement and guidelines on joint practice approved by the Society and the Wisconsin Nurses Association. The report also included an interpretation of the Wisconsin Nurse Practice Act as related to the "nurse practitioner."

Considerable discussion ensued. Doctor Peters recommended that the Joint Practice Committee (SMS and WNA) be requested to develop a Joint Practice Act for the State of Wisconsin, recognizing the combined role of physicians and nurses in patient care.

Doctors Natoli-Waterhouse moved that the Joint Practice Committee be so directed.

Doctor Eisenberg stated that the physician assistants are also interested in what supervision means as regards their role and moved an amendment that the Joint Practice Committee be directed to meet separately with the Physician Assistants Association to get a complete picture of the problem; seconded by Doctor Natoli and carried. The main motion carried as amended.

There was further discussion, especially in view of the then scheduled hearing, as to the meaning of "physician supervision" in relation to nurses or physician assistants, under present Wisconsin statutes, where such nonphysician personnel may be seeing patients either in the office or at a site some miles from the supervising physician.

On motion of Doctors Eisenberg-Peters, carried, physician supervision was considered to mean that there be periodic on-site supervision of nonphysician personnel in such circumstances, and that the patient be seen periodically by the physician.

D. Organizational Planning

(1) Committee on Economic Medicine

The Executive Committee had proposed a change of name and statement of responsibilities of the Committee on Economic Medicine because of apparently overlapping assignments to the latter and the Physicians Alliance Commission regarding professional liability.

The Council accepted the recommendation of the Economic Medicine Committee that its name not be changed, and also agreed that the matter of a Society sponsored or operated professional liability program for members should remain in this committee with informational input from the PAC subcommittee.

(2) Commission on Health Planning

On motion of Doctors Edwards-Flaherty, carried, the Council approved changing the name of the Commission on Health Facilities and Services to Commission on Health Planning and the following statement of responsibility:

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

6. Report of Nominating Committee

By various motions duly made, seconded and carried, the Council acted on nominations for appointments to expiring terms or vacancies on the commissions and committees of the Society. [These will be printed in the June 1978 *Wisconsin Medical Journal*.]

7. Physician Advertising

On motion of Doctors Larsen-Kief, carried, the Council adopted the following as the official SMS position on physician advertising, on recommendation of the Commission on Public Information:

> The State Medical Society of Wisconsin does not have a policy prohibiting advertising by physicians excepting that such advertising may not contain information that is false, misleading or deceptive. The American Medical Association has issued guidelines on Advertising and Solicitation which might be useful in helping physicians determine the appropriateness of advertising plans. These guidelines are not to be interpreted as rules or regulations of the State Medical Society of Wisconsin, but are for informational and guidance purposes only.

8. Foods and Nutrition

On motion of Doctors Edwards-Levin, carried, the Council, on recommendation of the Committee on School Health, adopted the following AMA statement on "confections and soft drinks in schools":

> One of the functions of a school lunch program is to provide training in sound food habits. The sale of foods, confections, and beverages in lunchrooms, recreation rooms, and other school facilities influences directly the food habits of the students. Every effort should be extended to encourage students to adopt and enjoy good food habits. The availability of confections and soft drinks on school premises may tempt children to spend lunch money for them and lead to poor food habits. Their high energy value and continual availability are likely to affect children's appetites for regular meals. Expenditures for soft drinks and most confections yields a nutritional return greatly inferior to that from milk, fruit, and other foods included in the basic food groups. When given a choice between soft drinks and milk or between candy and fruit, a child may choose the less nutritious. In view of these considerations, the (AMA) Council on Foods and Nutrition is particularly opposed to the sale and distribution of confections and soft drinks in school lunchrooms.

9. "Planning and Implementing a Health Promotion Program"

Doctor Eisenberg reported that this paper by Terry L Hankey, MD, was still under review by primary care representatives and the author, and requested that action be postponed until the August meeting.

10. Reporting by AMA Delegation

Doctor Natoli had requested specific discussion of the matter of communications to the membership from the Wisconsin delegation to the AMA. Suggestions were accepted that county societies be informed of the names and locations of the delegates and alternates, and that the PA staff assist in arranging for their appearances at meetings.

11. Specialty Section Membership Qualifications

On motion of Doctors Larsen-Eisenberg, carried, the Council approved the membership qualifications as submitted by the Section on Emergency Medicine.

On advice that the Resident Physicians Section, which held its organizational meeting the preceding day, had agreed to clarify in the bylaws that "unified" membership is required to be a section member, the Council approved the RPS membership qualifications on motion of Doctors Tuftee-Levin, carried.

12. Specialty Representatives on Governmental Affairs Commission

On motion of Doctor Edwards, seconded and carried, the Council approved the following as voting section representatives on GAC for 1978-79:

Emergency Medicine: Kurt Martyn, MD, Madison
Anesthesiology: Mark Backs, MD, Madison
Plastic Surgery: Donald M Levy, MD, Milwaukee
Resident Physicians: Alan Cohen, MD, Madison

13. Status Report on 1977 House of Delegates Actions

This was received for information, and had been circulated to the House of Delegates.

14. Annual Reports by Councilors

Doctor Kief proposed that despite House of Delegates defeat of all resolutions calling for a referendum on or rescission of the unified membership rule, a grass roots opinion poll be conducted on the subject to satisfy those members who desire a referendum.

On motion of Doctors Edwards-Natoli, carried, the Executive Committee was asked to consider a proposal for an opinion poll.

15. Annual Conflict of Interest Compliance Report

The Secretary reported that all those required to do so had submitted individual certificates. The statement and certificates will again be circulated to Council members, commission chairmen and responsible staff for annual completion.

16. Council Meeting Dates

The chairman announced the following meeting dates for the next year: June 3, including action on separation from WPSIC; August 5, October 14, November 11, 1978, and January 20, March 10, April 7, and May 9, 1979, followed by the annual meeting May 10-12.

17. Steering Committee on Peer Review

On motion of Doctors Peters-Larsen, carried, the Council approved the chairman's appointment of the following representatives of the Council, FMCE and WisPRO to the Steering Committee on Peer Review to implement the ad hoc committee report adopted by the House of Delegates:

Jules D Levin, MD
Blake E Waterhouse, MD
Paul G LaBissoniere, MD
Antoine Barrette, MD
Paul S Haskins, MD
John K Scott, MD, WisPRO
Kenneth O Johnson, MD, FMCE

The report also calls upon the Council to name "others, medical and nonmedical as indicated."

18. Nomination of George E Collentine, Jr, MD

On motion of Doctor Smejkal, seconded and carried, the Council authorized a letter of Society support of nomination and election of Doctor Collentine to the AMA Council on Medical Service.

19. Councilor Thomas J Doyle

On motion of Doctors Edwards-Foley, carried, the Secretary was directed to write a letter of appreciation to Doctor Doyle on his completion of three terms as councilor.

20. Miscellaneous

Action on a statement of interprofessional relations with physical therapists was postponed to the next meeting.

Doctor Motzel asked that consideration be given to Society officers holding positions as county society delegates.

Doctor Eisenberg requested that Council members be provided a paperback edition of Sturgis; approved on motion of Doctor Edwards, seconded and carried.

21. Adjournment

The meeting adjourned at 12:40 pm.

EARL R THAYER
Secretary

Approved June 3, 1978
PAUL S HASKINS, MD
Chairman

State Medical Society of Wisconsin

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MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of June 14, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

DANE

Anderson, John M, 20 S Park St, Madison 53715 (1941, Regular, Obstetrics and Gynecology, Certified)
Cullen, Randall K, 614 Walton Place, Madison 53704 (1949, Resident, Family Physician)
Horodysky, Orest R, 1300 University Ave, Madison 53706 (1949, Resident, Internal Medicine/Gastroenterology)
Merkow, Alan J, 18 Canterbury Circle, Madison 53711 (1945, Regular, Anesthesiology)
Micke, Bernard F, 5714 Odana Rd, Madison 53715 (1944, Regular, Family Physician, Certified)
Nelson, John M, 202 S Park St, Madison 53715 (1941, Regular, Internal Medicine, Certified)
Peterson, William G, 20 S Park St, Madison 53715 (1927, Regular, Neurology)
Poeschel, Bernard B, 3203 Patty Lane, Middleton 53562 (1941, Resident, Pathology)
Roley, Everett L, 20 S Park St, Madison 53715 (1931, Regular, Obstetrics and Gynecology, Certified)
Semian, David W, 4824 Sherwood Rd, Madison 53711 (1942, Regular, Orthopedic Surgery)

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Speichinger, James P, 20 S Park St, Madison 53715 (1945, Regular, Obstetrics and Gynecology)
Suh, Byungse, 5146 Anton Dr, Madison 53719 (1941, Resident, Internal Medicine, Certified)
Thorn, Nancy E, 1300 University Ave, Madison 53706 (1939, Resident, Anesthesiology/Emergency Medicine)
Wood, William W, 2650 Kendall Ave, Madison 53705 (1944, Resident, Psychiatry)

EAU CLAIRE-DUNN-PEPIN

Channer, John M, 2211 Stout Rd, Menomonie 54751 (1935, Regular, General Surgery, Certified)
Dennison, J Randall, 733 W Clairemont Ave, Eau Claire 54701 (1942, Regular, Urology, Certified)

FOND DU LAC

Sybesma, William G, 80 Sheboygan St, Fond du Lac 54935 (1946, Regular, Otorhinolaryngology)

LACROSSE

Park, Tai Jin, 1836 South Ave, LaCrosse 54601 (1936, Regular, Physical Medicine and Rehabilitation, Certified)

MILWAUKEE

Buan, Rolando R, 7421 N Crossway Rd, Fox Point 53217 (1943, Resident, General Surgery)

RACINE

Anderson, Robert G, 500 Walton Ave, Racine 53402 (1926, Regular, Ophthalmology, Certified)
Stone, William H, 5625 Washington Ave, Racine 53406 (1941, Regular, Internal Medicine/Hematology, Certified-IM)

ROCK

Nagle, Bruce K, 580 N Washington, Janesville 53545 (1943, Regular, Pediatrics, Certified)

WINNEBAGO

Rao, Muralidhara S, 1940 Evans St, Oshkosh 54901 (1950, Resident, Psychiatry)

WOOD

Conger, Charles, 400 Dewey St, Wisconsin Rapids 54494 (1949, Regular, General Practice)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

BROWN

Forbes, Kenneth A, Green Bay, to 5447 Oleta Turn, Long Beach, CA 90804

DANE

Bernard, Frank D, Madison, to 4050 Glidden, Sturgeon Bay 54235
Bloom, Robert F, Madison, to 3108 23rd St, Lubbock, TX 79409
Cooper, Garrett A, Green Valley, AZ, to 1512 Sumac Dr, Madison 53705
Goodman, George B, Marshfield, to 2116 University Ave, Madison 53705
Hert, Robert C Jr, Chicago, to 1013 Milton St, Madison 53715
Mortensen, Otto A, Madison to Stanford University, Stanford, CA 94305
Straughn, Robert A, San Antonio, TX, to 428 Lily Dr, Madison 53713
Wegenke, John D, Forth Worth, TX, to 6613 Inner Dr, Madison 53705

DODGE

Hanke, Richard W, Horicon, to 2421 North Terrace Ave, Milwaukee 53211
Justl, Robert N, Horicon, to 10 Tower Dr, Sun Prairie 53590

EAU CLAIRE-DUNN-PEPIN

Cameron, William G, North Fort Myers, FL, to 5575 North Shore Dr, Eau Claire 54701

FOND DU LAC

Gerend, Jacob M, Fond du Lac, to 705 Oak Tree Rd, Sheboygan 53081

MARINETTE-FLORENCE

Rogers, Raymond J, Lake Park, FL, to Rte 1, Box 49, Oconto 54153

MILWAUKEE

Jones, Frank E, Columbia, MO, to 21945 Galahad Lane, Brookfield 53005
Nemeth, Charles, Helmutt, NY, to PO Box 300, Marcy, NY 13403
Redlin, Russell R, Indio, CA, to 6440 Briarwood Lane, Waterford 53185

SAUK

Singh, Harjeet M, Reedsburg, to PO Box 370, Hazen, ND 58545

SHEBOYGAN

Gascoigne, C C, Bradenton, FL, to 513 Hilldale Ct, Madison 53705

WAUKESHA

Gruszynski, Thomas R, Wauwatosa, to 20561 Old Mill Rd, South Bend, IN 46637

DEATHS

Brzezinski, Edmund A, Milwaukee County, Mar 3, 1978
Pemberton, A H, Milwaukee County, Mar 6, 1978
Kassowitz, Karl E, Milwaukee County, Apr 6, 1978
Armstrong, Joshua H, Pierce-St Croix County, May 20, 1978
Bayley, Howard G, Jr, Dodge County, May 25, 1978
Schroth, George J, Marathon County, May 27, 1978
Walker, Lynn J, Milwaukee County, June 3, 1978 ■

OBITUARIES

◈County, State, AMA Members

Paul Gerhardt, MD, 67, Albany, NY, died Mar 13, 1978 in Albany. Born in Neenah, Doctor Gerhardt had been director of the New York Health Department's Cancer Control Unit from 1948 until 1975. He was an honorary life member of the American Cancer Society and past chairman of the executive committee of the Wisconsin Division of the American Cancer Society.

Clement J Morgan, MD, 76, Elmhurst, Ill, died Apr 25, 1978 in Sea Ranch Lakes, Fla. A 1928 graduate of Marquette University School of Medicine, Doctor Moran was a general practitioner and surgeon in LaCrosse and was on the medical staff of St Francis Hospital until he was called into service during World War II. He served for four years in the United States Army Medical Corps and then joined the medical staff of Hines Veterans Hospital, Hines, Ill, until his retirement. Surviving are two daughters, Mrs Neal (Patricia) Bidwell, Sea Ranch Lakes and Mrs James (Mary) Ewald of Elmhurst, Ill; two sons, Terence, Indianapolis, Ind, and Brian, Chicago, Ill.

◈ **Peter A Midelfort, MD,** 72, Eau Claire, died Apr 16, 1978 in Burlington, NC. Born Aug 5, 1905 in Eau Claire, Doctor Midelfort graduated from Harvard Medical School in 1931. He was a member and also served as president of the Midelfort Clinic from 1939-1968. He served in the United States Army Medical Corps from 1942-1946. From 1947-1966 he was preceptor for the University of Wisconsin Medical School and in 1972 was awarded the Medical Alumni Association's Max Fox Preceptor Award. In 1977 he received the University of Wisconsin's Medical Alumni Citation and also received the Good Samaritan Award from Luther Hospital in Eau Claire.

Surviving are his widow, Gerd; a son, Erik, North Garden, Va; and three daughters, Signe Dysken, Chicago; Elise, New York; and Kristin of Minneapolis.

◈ **Nat Goldberg, MD,** 70, Milwaukee physician for 40 years, died Apr 17, 1978 in Key Biscayne, Fla. Born June 21, 1907, Doctor Goldberg graduated from the Marquette University School of Medicine in 1931. In 1948 he was appointed police surgeon of Milwaukee, a position he held for 20 years, and in 1955, he instituted a training program in mouth-to-mouth resuscitation for the Milwaukee Police Department, one of the first such programs in the country. He founded the Goldberg Medical Clinic in 1962. Surviving are his widow, Shirley, and a son, Dr Henry M, of Milwaukee.

◈ **Howard G Bayley, MD,** 63, Beaver Dam, died May 25, 1978 in Washington, DC. Born Dec 21, 1914 in Battle Creek, Mich, Doctor Bayley graduated from Northwestern University School of Medicine in 1942. He served in the United States Army Medical Corps from 1943-1946. Doctor Bayley, an active member in many professional organizations, was commended by the Board of Directors of the Wisconsin Radiological Society for his 13 years of service to the society as a member of the board, secretary-treasurer, president, and also as a councilor in 1973.

Doctor Bayley was a member of the Executive Committee and the Finance Committee of the State Medical Society while serving as a councilor from District I from 1967-1969. He also was a member of the Society's Commission on Hospital Relations and Medical Education (now the Health Planning Commission) from 1959-1965. Doctor Bayley also was active in the affairs of the Dodge County Medical Society being a member since 1950 and serving as its president in 1954.

Surviving are his widow, Ardeth; and one son, James B Bayley, Washington, DC.

◈ **Lynn J Walker, MD,** 86, Milwaukee, died June 3, 1978 in Milwaukee. Born May 4, 1892 in Wykoff, Minn, Doctor Walker graduated from Jefferson Medical College, Philadelphia, Pa, in 1916. He served in the United States Army Medical Corps during World War I. Doctor Walker had practiced in Milwaukee for 50 years. Surviving are his daughter, Dorothy Baxter, Arcadia, Calif; and a stepson, Robert Kruecke of Lake Bluff, Ill. ■

HELPING THE RETARDED/DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be retarded. When a family comes to the physician with this situation he should have two concerns: the needs of the parents and the emotional stress on the family and that the child receives a proper evaluation.

Much of the family's emotional stress may be caused by their lack of understanding, or their misunderstanding, of mental retardation. The physician may be the best person to discuss the parent's concerns and fears as they have come to him seeking help. A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. They can put the parents in contact with other parents who have experienced similar situations. Also, there should be local professionals available who have experience working with the retarded individual and his family. A call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

The second concern is the child in question. Early and proper evaluation will answer many of the parent's questions and be the first step in programming for the child if it is needed. The local Developmental Disabilities Board or Unified Board will be of service here also. There should be local resources, psychological services, OT, etc. available to complement the physician's examination. There are also several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

Dr June Dobbs, Director
CHILD DEVELOPMENT CENTER
Milwaukee Children's Hospital
1700 West Wisconsin Avenue
Milwaukee, Wisconsin
(414) 344-7100

Dr Charles Schoenwetter
UNIVERSITY HOSPITALS
1552 University Avenue
Madison, Wisconsin 53706
(608) 262-9983

Ms Marilyn Gratto
COMPREHENSIVE EVALUATION CLINIC
FOR MULTIPLI-HANDICAPPED CHILDREN
Miller-Dwan Hospital
502 East 2nd Street
Duluth, Minnesota 55805

Linne Cain, Intake Coordinator
WAISMAN CENTER ON MENTAL
RETARDATION
1500 Highland Ave
Madison, Wisconsin 53706
(608) 263-5776

Further information may be obtained from Rosemarie Reed, Information and Referral Outreach, Wisconsin Association for Retarded Citizens, Inc, 2700 Laura Lane, Middleton, Wis 53562; (608) 831-3444.

OFFICERS OF SPECIALTY SECTIONS OF THE STATE MEDICAL SOCIETY
June 19, 1978

SECTION ON:
ALLERGY AND CLINICAL IMMUNOLOGY
Chairman ..... Raymond L Hansen, MD, 1000 N Oak Ave, Marshfield 54449
Secretary-Treas ..... Morton M Soifer, MD, PO Box 17717, Milwaukee 53217
Delegate ..... John J Ouellette, MD, 1 S Park St, Madison 53715
Alternate ..... S Roger Hirsch, MD, PO Box 17717, Milwaukee 53217

ANESTHESIOLOGY
Chairman ..... Richard A Manhart, MD, Rte #2, Maurer Rd, Cross Plains 53528
Secretary-Treas ..... Vacancy
Delegate ..... James T Small, Jr, MD, 904 Tenny Ave, Waukesha 53186
Alternate ..... Warren J Holtey, MD, 1000 N Oak Ave, Marshfield 54449

DERMATOLOGY
Chairman ..... Sharon D H Lantis, MD, 1552 University Ave, Madison 53706
Secretary-Treas ..... Vacancy
Delegate ..... Joel E Taxman, MD, 1622 W Wisconsin Ave, Milwaukee 53233
Alternate ..... Hubert W Moss, Jr, MD, 30 S Henry St, Madison 53703

EMERGENCY MEDICINE
Chairman ..... C Randolph Turner, MD, 7335 Maple Terr, Milwaukee 53213
Secretary-Treas ..... Richard J Krill, MD, 8200 N Teutonia, Milwaukee 53209
Delegate ..... William E Hein, MD, 2410 Lina Lane, Green Bay 54304
Alternate ..... C Randolph Turner, MD, 7335 Maple Terr, Milwaukee 53213

FAMILY PHYSICIANS
Chairman ..... James N Moore, MD, 5714 Odana Rd, Madison 53711
Secretary-Treas ..... John O Grade, MD, 1050 Legion Dr, Elm Grove 53122
Delegate ..... Robert F Purtell Jr, MD, 3316 W Wisconsin Ave, Milwaukee 53208
Alternate ..... John O Grade, MD, 1050 Legion Dr, Elm Grove 53122

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Secretary-Treas ..... Michael J Mally, MD, 1004 E Sumner St, Hartford 53027
Delegate ..... Michael P Mehr, MD, 1000 N Oak Ave, Marshfield 54449
Alternate ..... Michael J Mally, MD, 1004 E Sumner St, Hartford 53027

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Secretary-Treas ..... Vacancy
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Alternate ..... Manucher J Javid, MD, 1300 University Ave, Madison 53706

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Secretary-Treas ..... Francis M Forster, MD, 4020 County M, Middleton 53562
Delegate ..... Francis Kruse, Jr, MD, 1000 N Oak Ave, Marshfield 54449
Alternate ..... Michael McQuillen, MD, 8700 W Wisconsin Ave, Milwaukee 53226

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Alternate ..... Ralph L Suechting, MD, 240 First St, Neenah 54956

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Secretary-Treas ..... Michael L Stevens, MD, 1000 N Oak Ave, Marshfield 54449
Delegate ..... William E Martens, MD, 10425 W North Ave, Wauwatosa 53226
Alternate ..... Robert P Reik, MD, 10425 W North Ave, Wauwatosa 53226

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Co-Chairman ..... Arthur W Tacke, MD, 777 W Glencoe Pl, Milwaukee 53217
Walter E Gager, MD, 14935 Franklin Dr, Brookfield 53005
Secretary-Treas ..... Edwin L Downing, MD, 719 Doctors Ct, Oshkosh 54901
Delegate ..... Dennis K Ryan, MD, 1836 South Ave, LaCrosse 54601
Alternate ..... Dennis J Kontra, MD, 5814 Washington Ave, Racine 53406

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Secretary-Treas ..... Gerald P Gredler, MD, 510 N Terrace St, Janesville 53545
Delegate ..... Paul A Jacobs, MD, 1218 W Kilbourn Ave, Milwaukee 53233
Alternate ..... Roger P Johnson, MD, 8700 W Wisconsin Ave, Milwaukee 53222

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Secretary-Treas .....
Delegate ..... Thomas W Grossman, MD, 10520 N Port Washington, Mequon 53092
Alternate ..... Donald S Blatnik, MD, 10625 W North Ave, Wauwatosa 53226

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Secretary-Treas ..... Charles P Nichols, MD, 709 S 10th St, LaCrosse 54601
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Alternate ..... Robert E Carlovsky, MD, 222 Cottage Ave, Fond du Lac 54935

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Chairman ..... John R Guy, MD, 700 Oxford Rd, Waukesha 53186
Secretary-Treas ..... Vacancy
Delegate ..... Richard L Myers, MD, 1821 S Webster Ave, Green Bay 54301
Alternate ..... William H Bartlett, MD, 213 Carillon Dr, Madison 53705

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Secretary-Treas ..... Basilio Lopez, MD, 2025 E Newport Ave, Milwaukee 53211
Delegate ..... Salvatore A Spicuzza, MD, 2400 W Villard Ave, Milwaukee 53209
Alternate ..... William J La Joie, MD, PO Box 1285, Waukesha 53186

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Secretary ..... Jerome J Luy, MD, 400 W Silver Spring Dr, Milwaukee 53217
Delegate ..... Harold J Hoops, MD, 704 S Webster, Green Bay 54301
Alternate ..... George J Korkos, MD, 2300 N Mayfair Rd, Milwaukee 53226

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Chairman ..... Robert F Goerke, MD, 811 E Wisconsin Ave, Milwaukee 53202
Secretary-Treas ..... George Arndt, MD, 706 E Forest Ave, Neenah 54956
Delegate ..... Charles W Landis, MD, 2350 N Lake Dr, Milwaukee 53211
Alternate ..... C E McDaniel Moore, MD, 153 S Macy, Fond du Lac 54935

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Secretary-Treas ..... George H Handy, MD, 211 S Whitney Way, Madison 53705
Delegate ..... Gabriel P Ferrazzano, MD, City Hall, Rm 106, Racine 53401
Alternate ..... Richard W Biek, MD, 1029 N Jackson St, Milwaukee 53202

RADIOLOGY

Chairman ..... Donald P Babbitt, MD, PO Box 1997, Milwaukee 53201
Secretary-Treas ..... Daniel J Price, MD, 2400 Villard Ave, Milwaukee 53209
Delegate ..... Robert C Feulner, MD, 611 Westminister, Waukesha 53186
Alternate ..... Marcia J S Richards, MD, PO Box 503, Milwaukee 53201

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Delegate ..... Donn D Fuhrmann, MD, 3175 S 28th St, Milwaukee 53215
Alternate ..... T Bayard Frederick, MD, 402 Wisconsin Ave, Marshfield 54449

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Chairman ..... Edward A Bachhuber, MD, 8700 W Wisconsin Ave, Milwaukee 53226
Secretary-Treas ..... Raymond R Watson, MD, 941 E Wye Lane, Fox Point 53217
Delegate ..... Thomas J Beno, MD, 1751 Deckner Ave, Green Bay 54302
Alternate ..... Louis C Bernhardt, MD, 501 Shearwater Rd, Madison 53714

UROLOGY

Chairman ..... John D Silbar, MD, 2040 W Wisconsin Ave, Milwaukee 53233
Secretary-Treas. .... Raul F Waters, MD, 1313 Fish Hatchery Rd, Madison 53715
Delegate ..... Daniel B Gute, MD, 6300 N Port Washington Rd, Milwaukee 53217
Alternate ..... Charles W Troup, MD, 2021 S Webster Ave, Green Bay 54301 ■

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Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

***Respiratory tract infections** due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus*.

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli*, and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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NEWS HIGHLIGHTS

Ten of the thirteen surviving charter members of the Milwaukee Gynecological Society were honored during the 25th annual meeting of the Society in Milwaukee. Standing left to right are: Saul F Schwartz, MD;* Fred J Hofmeister, MD;* Jack A Klieger, MD;* Lester H Verch, MD;* David J Werner, MD;* William F Hovis, MD;* Carlton Wirthwein, MD; and Lionel T Servis, MD.* Seated left to right: Malcolm M Hipke, MD;* and Benjamin E Urdan, MD.* All are from the greater Milwaukee area. Unable to attend were Roland S Cron, MD;* R E McDonald, MD; and John Thoma, MD.*

The Milwaukee Gynecological

. . . Society installed the following physicians as its officers for the year 1978-79. They are MDs William Finlayson,* Milwaukee, president; Walter R Schwartz,* Wauwatosa, president-elect; and Stanley Korducki,* Wauwatosa, as secretary-treasurer. The officers were installed at the 25th annual meeting of the Society.

American College of

. . . Radiology, recently announced fellows of the College from Wisconsin. They are MDs Marvin L Hinke,* Marshfield; Ralph O Kennedy,* Appleton; Donald J Ryan,* Neenah; James A Schelble,* Fox Point; and Loren L Thompson* of Green Bay.

Madison's Clinical Science Center

. . . moves continue as the Neurology Clinics and Psychiatric Nursing Intervention Clinic in May joined the Clinical Cancer Center and School of Nursing who had moved in earlier this year and last fall. This summer the following outpatient clinics are tentatively scheduled to move to the new building: Dermatology, Chemosurgery, Ear-Nose-Throat, Ambulatory Pediatrics, and Prenatal Service. The last to move in will be the medical school clinical departments and University Hospitals, both scheduled for March 1979.

Family Physicians

. . . of the Wisconsin Academy of Family Physicians elected the following officers at the organization's annual meeting in Eau Claire: Robert F Purtell Jr, MD,* Milwaukee, president-elect; John O Grade, MD,* Elm Grove, secretary-treasurer; Henry Rahr, MD,* Green Bay, speaker; and Jack Strong, MD,* Mauston, vice-speaker, James N Moore, MD,* Madison, was installed as the new president.

The Accreditation Council

. . . for Ambulatory Health Care of the Joint Commission on Accreditation of Hospitals has awarded four-year accreditation status to the following Wisconsin groups: Kurten Medical Group, SC, Racine, and Milwaukee Medical Clinic, Milwaukee. Information concerning AC/AHC accreditation may be obtained from the Program Director, AC/AHC, 875 North Michigan Ave, Chicago, Ill 60611. ■

PHYSICIAN BRIEFS

Addis C Costello, MD*

. . . Milwaukee, recently was given a special recognition award by the American Society of Internal Medicine during its annual meeting. He was singled out for his leadership in the development of the Professional Standards Review Organization for Southeastern Wisconsin and for his activities on behalf of the Wisconsin Society of Internal Medicine. Doctor Costello served as the first president of the Foundation for Medical Care Evaluation of Southeastern Wisconsin.

Roland R Liebenow, MD*

. . . Lake Mills, has been promoted from assistant to associate medical director of Northwestern Mutual Life Insurance Co, Milwaukee. Prior to joining the staff of Northwestern Mutual, Doctor Liebenow was chief-of-staff of Watertown Memorial Hospital and vice-chief-of-staff of Fort Atkinson Memorial Hospital.

Frank McCullough, MD*

. . . formerly of the Deckner Clinic in Green Bay, recently became associated with the Medical College of Ohio, Toledo, as associate professor of medicine and director of the division of gastroenterology. Doctor McCullough had been associated with the Clinic for five years, and was chief of medicine at St Vincent Hospital in 1976. He also served as chairman of the Combined Hospitals Credentials Committee in 1977-78.

Ben R Lawton, MD*

. . . past president of the Marshfield Clinic, recently received the 1978 medical alumni citation at the University of Wisconsin Medical School's alumni day. A 1946 graduate of the Medical School, Doctor Lawton is a past president of the Wisconsin Medical Alumni Association.

Quentin W Thomas, MD

. . . Eagle River, recently joined the medical staff of Eagle River Memorial Hospital. A thoracic surgeon, Doctor Thomas graduated from the University of Colorado School of Medicine and served his residencies at the University of Wisconsin, Madison, and at Marquette University School of Medicine. Doctor Thomas previously had been in practice in Idaho.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

George Owen, MD*

. . . chairman of the board of the Midlefort Clinic of Eau Claire, recently announced the Midelfort Clinic physicians who spoke at the scientific program sponsored by the Clinic. The MDs who participated in the program are Leslie Spitz,* Terrance R Borman,* James W Merritt,* Tom Brown,* James Bounds,* and Patrick Macken.* The program is offered two or three times a year and physicians from Chippewa, Eau Claire, Rusk and Pepin counties are invited to attend.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1978

2 2nd Councilor District Meeting
4 Dane County Medical Society Board of Trustees
5 Health Care Coalition
5 University of Wisconsin Preceptors
6 WisPRO Review and Evaluation Committee
6 Fetal Alcohol Syndrome
11 Joint Committee on Wisconsin Elective Surgical Practice
12 *Finance Committee of SMS Council (Milwaukee)*
12 *Committee on Economic Medicine of SMS Council (Milwaukee)*
12 *Executive Committee of SMS Council (Milwaukee)*
12 *SMS Council (Milwaukee)*
13 WisPRO South Central District Review Council
13 *SMS Specialty Sections Delegates Caucus (Milwaukee)*
13 *SMS House of Delegates First Session (Milwaukee)*
13 *Open Hearings, AMA Delegates (Milwaukee)*
13 *House of Delegates Reference Committee Meetings (Milwaukee)*
13 *SMS Annual Meeting (Milwaukee)*
13 *SMS Auxiliary Annual Convention (Milwaukee)*
14 *SMS House of Delegates Second Session (Milwaukee)*
14 *SMS Annual Meeting (Milwaukee)*
14 *SMS Auxiliary Annual Convention (Milwaukee)*
14 *SMS Specialty Section on Resident Physician (Milwaukee)*
15 *SMS Specialty Sections on Anesthesiology, Ophthalmology, Pathology (Milwaukee)*
15 *SMS Annual Meeting (Milwaukee)*
15 *SMS House of Delegates Third Session (Milwaukee)*
15 *SMS Auxiliary Annual Convention (Milwaukee)*
15 *SMS Council (Milwaukee)*
18 Southwest Physicians Task Force on Health Planning
20 SMS Commission on Peer Review
21 SMS Physicians Alliance Commission
21 SMS Medical Defense Committee
28 SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parentheses.

Terry A Hankey, MD*

. . . Waupaca, recently was appointed by Acting Governor Martin J Schreiber, to the Governor's Prevention and Wellness Commission. Doctor Hankey was among 37 people appointed to serve on the panel to promote health and prevent illness.

Judith S Pagano, MD

. . . Rhinelander, recently joined the medical staff of the W S Bump Medical Group, SC. Doctor Pagano, an obstetrician-gynecologist, graduated from the University of Michigan Medical School and served her internship at Baptist Memorial Hospital, Memphis, Tenn. Her residency training was taken at the University of Michigan and since then has been a member of the teaching staff there.

Charlotte Burns, MD*

. . . Rice Lake, recently opened her office in the practice of ophthalmology. Doctor Burns graduated from the University of Wisconsin Medical School, Madison, and served her internship and residency at the University of Iowa. She also was on the staff as an assistant professor in the eye department and was director of contact lenses in the university hospital until 1971. She practiced in Altus, Okla, and also did volunteer work in missionary hospitals in Tanzania and Northern Thailand. Doctor Burns was in private practice in Tucson, Ariz, before moving to Rice Lake.

Robert A Helminiak, MD

. . . Sheboygan, recently became a member of the medical staff of the Sheboygan Clinic. Doctor Helminiak graduated from the University of Wisconsin Medical School. He served his internship and residency at Milwaukee County General Hospital. During the past year he has served as a faculty member and instructor at the Medical College of Wisconsin while also serving in clinical assignments in the Milwaukee area.

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Pedro O Ranola, MD

. . . Edgerton, recently became associated with the Edgerton Clinic. He is a graduate of the University of Santo Tomas, Manila, The Philippines. He served his internship at St Michael Hospital, Milwaukee, and also at Sinai Hospital in Baltimore, Md. Doctor Ranola, prior to moving to Edgerton, had been in medical practice at the Grafton Clinic, Grafton, ND since 1973.

Robert Stader, MD

. . . Wichita, Kan, has joined the medical staff of the Grant Community Clinic, Lancaster. Doctor Stader, a graduate of the University of Wisconsin Medical School, Madison, is completing his family practice residency program in Wichita and will begin his medical practice in August.

John C Shields, MD*

. . . Lancaster, recently joined the staff of the Unified Board of Grant and Iowa counties as full-time medical director. Doctor Shields graduated from Syracuse University College of Medicine and had been in private practice in Pasadena, Tex, and La-Crosse. Prior to his move to southwest Wisconsin, Doctor Shields was the medical director of the Monroe County Unified Board.

James P Schieffer, MD

. . . Madison, recently has joined the medical staff of the Cross Plains Clinic. Doctor Schieffer had been associated with the Quisling Clinic, Middleton, and is on the medical staff of Madison General Hospital. He will be associated with Robert Bedard, MD in Cross Plains.

Gabriel P Ferrazzano, MD*

. . . Racine's health commissioner, recently was honored by the Wisconsin Public Health Association for distinguished professional achievement, leadership, and service to the community and association. Doctor Ferrazzano, a past president of the association, will retire this year as the city's health officer. He also is a past president of the Section on Public Health and Preventive Medicine of the State Medical Society.

Charles J Anderson, MD*

. . . Madison, an assistant clinical professor of ophthalmology at University Hospitals, has joined the medical staff of Davis-Duehr Eye Associates, SC, Madison.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1978

1 Dane County Medical Society HMP Committee
2 Dane County Medical Society Board of Trustees
2 Dane County Medical Society Public Health Advisory Committee
2 Health Care Coalition
4 Division Executive Committee of The American Cancer Society
4 Ad Hoc Committee to Study Quality Care Activities
9 WHCRI-Ad Hoc Program Evaluation Committee
9 SMS Committee on Safe Transportation
10 SMS Commission on Governmental Affairs
10 SMS Committee on Federal Legislation
10 SMS Committee on Environmental Health
12 Maternal Mortality Study Committee
12 Work Week of Health Planning
15 Cost Evaluation Committee
18 Steering Committee on Peer Review
18 Wisconsin Immunization Initiative Coordinating Committee
20 SMS Physicians Alliance Commission
20 SMS Medical Defense Committee
23 SMS Committee on Aging and Extended Care Facilities
24 SMS Commission on Health Planning
24 Resident Physician Section
26 Planning Meeting-1979 Annual Meeting-CCME and Specialty Sections

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

Richard Shropshire, MD*

. . . Madison, recently rejoined the Monona Grove Clinic. He had been director of Madison residency in the Department of Family Medicine and Practice at the University of Wisconsin Medical School. He previously had been associated with the Clinic from 1957 through 1975.

John A Walker, MD*

. . . Milwaukee, recently became president of the medical staff of St Luke's Hospital. Other MDs elected to offices are: Richard H Strassburger,* Wauwatosa, president-elect, and Armin R Baier,* also of Wauwatosa, secretary-treasurer.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1978

2 Steering Committee on Peer Review
3 SMS Council
3 Committee on Economic Medicine of SMS Council
3 Finance Committee of SMS Council
5 Madison Society of OB/GYN
6 Dane County Medical Society Board of Trustees
6 Madison Surgical Society
7 WisPRO Criteria Committee
8 WisPRO Review and Evaluation Committee
9 WisPRO District Managers
9 Lead Review Coordinator Meeting
12 Task Force on Health Screening and Immunization
13 Dane County Medical Society General Membership
14 SMS Committee on Occupational Health
14 Ad Hoc Committee on Quality Care Activities
16 SMS Physicians Alliance Commission
16 SMS Medical Defense Committee (now called Medical Liability Committee)
21 SMS Commission on Mediation and Professional Ethics
26 Health Education Problems Advisory Committee
29 WisPRO South Central District Review Council
29 Wisconsin Immunization Initiative Coordinating Committee—Records Committee
29 Interim Steering Committee on Peer Review

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

David L Heber, MD
John A Smith, MD

. . . recently joined the medical staff of the Flyway Medical Clinic, Horicon. Doctor Heber graduated from the University of Wisconsin Medical School, Madison, and served his residency at the Hahnemann Medical College and Hospital, Philadelphia. Doctor Smith, a graduate of the Ohio State University Medical School, served his residency in family practice in the Canal Zone before moving to Humacao, Puerto Rico. In Puerto Rico he was the medical director and administrator of the Ryder Memorial Hospital. For the past two years, he has been employed by the National Health Service Corps.

Charles E Pitzele, MD

. . . West St Paul, Minn, recently became associated with the Hudson Clinic, SC, as a consultant in pediatrics. A graduate of the University of Indiana Medical School, he did his internship and residency at Indiana University Medical Center, Children's Memorial Hospital, and Northwestern University, Evanston, Ill. He is a member of the medical staff of Hudson Memorial Hospital.

Mohammed Saleem, MD*

. . . Bayside, recently opened his office in Saukville. A 1964 graduate of King Edward Medical College, Lahore, Pakistan, Doctor Saleem interned at St Agnes Hospital, Philadelphia, Pa, and served his residency at the Mayo Clinic, Rochester. Doctor Saleem has been practicing surgery in Milwaukee since 1972 and has been affiliated with St Michael's, Family, Mount Sinai, Columbia, and St Luke's hospitals.

George E Magnin, MD*

. . . Marshfield, outgoing governor of the Wisconsin Chapter, American College of Physicians, has been named to a four-year term as a member of the Governing Council of the Wisconsin Society of Internal Medicine.

James C H Russell, MD*

. . . Fort Atkinson, recently received the "Outstanding Community Leader Award" from the Jefferson County Reserve Officer Association. He is a graduate of the University of Wisconsin Medical School, Madison, and has practiced in Fort Atkinson since 1945. Doctor Russell is the Fort Atkinson High School team physician and also has similar duties for the University of Wisconsin, Whitewater.

John S Holcenberg, MD

. . . Whitefish Bay, professor of pediatrics and pharmacology, Medical College of Wisconsin, recently was named a Burroughs Wellcome scholar in clinical pharmacology for 1978. Doctor Holcenberg graduated from the University of Washington School of Medicine in 1961.

Mary K Kubiak, MD*

. . . Oshkosh, recently resigned her position as medical director of Park View Health Center. Doctor Kubiak has accepted the position as staff physician with the Health Maintenance Program of Kimberly Clark Corporation. She has been medical director of Park View Health Center since January 1976.

John A Walker, MD*

. . . Wauwatosa, recently was elected to a two year term as president of the medical staff of St. Luke's Hospital. Other MDs elected are Richard H Strassburger, MD,* Wauwatosa, president-elect; and Armin R Baier,* Wauwatosa, secretary-treasurer. Doctor Walker succeeds Donald J Chrzan, MD of Greendale. ■

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WPS

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for Wisconsin Physicians

Volume VII, Number 4 July 1978

MEDICAL ADVISORY SYSTEM

In order to assure the accurate adjudication of medically difficult claims, WPS utilizes a review process called the Medical Advisory System.

The system is composed of "in-house" physician medical advisors and a network of outside specialists in the fields of psychiatry, general surgery, neurology, dermatology, ENT, plastic surgery, orthopedics, allergy, cardiovascular surgery, neurosurgery and urology. These physician consultants are selected on the basis of the professional respect in which they are held by their colleagues as well as their geographical location.

When an unusually complex claim arrives at WPS, an adjustor refers it to a technician on the WPS staff who specializes in that medical area. If the technician cannot satisfactorily determine WPS' liability in the claim, he or she submits it to a medical advisor for review. Should the medical advisor feel the need for a specialty opinion on the claim, WPS sends it to one of the outside specialists for further review. On occasion and for especially difficult medical problems, two specialists may be consulted. If a claim is sent to one of the outside specialists, all references to the attending physician and patient's name are removed to assure complete confidentiality.

In every case, the opinions provided by an advisor are reviewed by another advisor, who is actively practicing. Any opinion rendered by the medical advisors is purely medical: neither they nor the specialists make any final decision on whether, or how much, WPS can pay on a given claim under the health insurance contract. These physicians are called upon as medical experts, not as interpreters of WPS insurance policies. So far this year, approximately 550 claims have been reviewed through the Medical Advisory System.

The Medical Advisory System provides a method of screening claims in order to arrive at accurate decisions on medically complex claims. The graduated process of review can be regarded as a claims "appeal" process, each stage of which progressively tests the information the claim contains.

The aim of the system is to determine accurately what was actually done in light of the diagnosis and to determine accurate and fair payment under the WPS health policy. The process serves other purposes as well, such as analysis of new procedures for which there is no claims adjusting precedent.

The advisory process also helps control costs by assuring that WPS does not pay health care expenses which are not contracted for by its subscribers, without sacrificing the quality of health care our subscribers receive.

***Report** is a service to the physicians of Wisconsin.*

11440-006-7807

and their Medical Assistants

Proper claims filing . . . Faster claims processing

The medical assistant is a direct participant in the claims processing cycle. Because several steps are involved in the paperwork involved with claims processing, claims payment takes a certain amount of time. Unnecessary delay in processing time can, however, be eliminated by following few simple rules.

WPS has designed a "Physician's Service Report" and "Hospital Insurance Form" for ease of filing and processing. Necessary information is blocked off for processing convenience in both the physician's office and at WPS.

Delays of several days can occur when incomplete or incorrect information is submitted to the Claims Department. Further loss of time can result when statements for services not yet processed by WPS are sent to the patient for payment.

A common claims filing problem is inaccurate and incomplete listing of subscriber and provider numbers. WPS subscriber numbers have seven digits which must be included on all claim forms. A complete provider number as well as name and address must also be given.

Using the correct claim form itself is essential. Many WPS claims are received in our office for subscribers of other insurance companies. This is especially true for Blue Cross-Surgical Care Blue Shield subscribers. When we receive a WPS claim form that should be submitted to another carrier, claims payment to their subscriber or a provider is also delayed.

Paperwork is a fact of modern day life. If it cannot be avoided, at least it can be made simpler. Our forms have been designed to aid you in speedy and efficient filing.

A REMINDER

Since the formal separation of WPS from the State Medical Society is now complete, it is important that claims, letters and inquiries be sent to the proper WPS post office box number and not to the box number formerly shared by the two organizations.

For your reference, we are providing you with a list of WPS box numbers and their zip codes.

WPS	Box 8190	53708
State Account & Major Medical	Box 2573	53701
Formal Referrals (HMP)	Box 7932	53707
Medicare	Box 1787	53701
CHAMPUS (Hosp. Claims)	Box 7923	53707
CHAMPUS (Excluding Hosp.)	Box 7953	53707
CHAMPUS (General)	Box 7927	53707

Sending correspondence to any box number than those given above will delay the processing of your claims and inquiries. We appreciate your cooperation.

NEWS YOU CAN USE

AMERICANS REACT TO 'MEDICINE IN AMERICA'

A random poll of 600 viewers taken by NBC following its three-hour TV program titled, "Medicine in America: Life, Death and Dollars," brought these responses:

—When asked whether they would consider suing a physician for malpractice, 7% of those polled said they would, 92% that they would not.

—When asked about their attitude toward the medical care system in general, 61% rated it excellent to good and 35% fair to poor.

—Queried as to whether they believed there was unnecessary surgery, 50% said yes, 34% no, 16% had no opinion.

Reactions to the program among state medical societies was varied but generally favorable.

COUNTERSUITS AND FRIVOLOUS MEDICAL MALPRACTICE ACTIONS

A discussion of the "countersuit question" (filing a cross-complaint against the patient's attorney in the malpractice action) is contained in the recently prepared SMS paper: "Memorandum on Countersuit in Wisconsin." The paper, prepared by the Society's Medical Defense Committee, explains why countersuits and a legal negligence standard for attorneys (as in the widely publicized Berlin case) have not been established in Wisconsin.

BRITAIN TRAVEL OPPORTUNITY AVAILABLE

All SMS members and auxiliary have an opportunity to travel to Britain next fall. Each SMS member was mailed a flyer outlining the details of the trip scheduled for September 20-28, 1978. Participating individuals will choose between two travel programs: one offered independence for those who want to sightsee by themselves, and another, guided tour. Watch for details in your mail.

NEW DISEASE CLASSIFICATION SYSTEM AVAILABLE SOON

The *International Classification of Diseases,* 9th Revision, Clinical Modification *(ICD-9-CM)* will be published by the Commission on Professional and Hospital Activities (CPHA) in May of 1978. *ICD-9-CM* is the new disease classification system to be used for hospital coding of medical records, ambulatory and other medical care programs furnishing clinical descriptions of patients; conducting clinical and epidemiological research; psychiatric coding; and reporting, compiling and comparing health-care data. To order a copy write: *ICD-9-CM,* PO Box 991, Ann Arbor, MI 48106.

SMS URGES LEGISLATURE TO TIGHTEN TAX RECORD ACCESS

The State Medical Society is strongly urging the Legislature to adopt a provision in the Budget Review Bill AB 1220 that will tighten up the access to personal income tax records in Wisconsin. The provision, as drafted by the Department of Revenue, would authorize only one legislative committee to grant access to tax records, rather than all legislative committees as is currently the case. This action follows public disclosure that a UW-Madison student had been given authority by a State Senate committee to examine nearly 3,000 physician income tax returns.

DON'T FORGET TO USE THE SMS TOLL-FREE NUMBER!

Reminder: the toll-free line for SMS members' use in calling the Society is open from 8:00 AM to 4:30 PM, Monday through Friday. THE NUMBER TO DIAL IS: 1-800-362-9080. ■

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS

. . . is a non-dues-paying organization of PHYSICIANS AND DENTISTS who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held at the Sheraton-Southfield Hotel, Southfield, Mich, Aug 3-6, 1978. Tax deductible. Inquirers and newcomers welcome. For info: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511.

CARDIAC POTPOURRI

Friday, Sept 8, 1978

Midway Motor Lodge
1835 Rose Street
LaCrosse, Wis

Presented by Adolf Gundersen Medical Foundation, LaCrosse Lutheran Hospital Heritage Club, and Wisconsin Heart Association

Program:

am
- 7:30 Registration
- 7:55 Welcome
- 8:00 "Physical Activity and Coronary Artery Disease-Epidemiologic Data," *Ralph F Paffenberger, MD*
- 9:00 "Long Term Followup Aorto-Coronary Bypass Patients," *Robert J Hall, MD*
- 10:00 Coffee Break
- 10:30 "Impact-Surgically Corrected Congenital Heart Lesions on Adult Practice —Warnings, Special Problems and Long Term Outlook," *S Gilbert Blount, MD*
- 11:30 Discussion

pm
- 12:15 Luncheon
- 1:30 "Difficult Arrhythmias-Diagnosis and Management," *William P Nelson, MD*
- 2:30 "New Concepts-Old Drugs. Digitalis and Pronestyl," *Frank I Marcus, MD*
- 3:30 Discussion
- 4:00 Adjourn

Registration deadline: Sept 1.

Program fee $20. Approved 6 hours of CME Category I credit by the AMA-PRA. Info: Medical Education Office, Gundersen Clinic, Ltd, 1836 South Ave, LaCrosse, Wis 54601.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 WISCONSIN

Aug 17-19: *Primary Care—A View toward the 80's* at Interlaken Lodge/Villas, Lake Geneva, Wis. Dept. of Medical Education, Ravenswood Hospital Medical Center, 4550 N. Winchester at Wilson, Chicago, Ill 60640. Contact: Mara Harrington, Secretary, tel: 312/878-4300. CME Category I credit by the AMA. g6-7/78

Sept 8: *Cardiac Potpourri*, presented by Adolf Gundersen Medical Foundation, LaCrosse Lutheran Hospital Heritage Club, and Wisconsin Heart Association. Midway Motor Lodge, 1835 Rose St, LaCrosse 54601. Further details appear elsewhere in this section.

Sept 11-13: *New Horizons in Rheumatic Diseases* at Rochester, MN. Accepted for 18¾ hours of Category I credit of the AMA-PRA. Info: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

Sept 14-16: *Wisconsin Society of Internal Medicine*, at Browns Lake Resort, Burlington.

Sept 15-16: *Wisconsin Surgical Society*, Holiday Inn, Wausau, Wis 54401

Sept 15-16: *Wisconsin Neurosurgical Society*, Gundersen Clinic, LaCrosse, Wis 54601

Sept 22: Wisconsin Society of Plastic Surgery, Brynwood Country Club, Milwaukee.

Sept 23-24: Wisconsin Allergy Society, Olympia Resort, Oconomowoc.

Sept 23-24: *Wisconsin Society of Anesthesiologists*, Playboy Club, Lake Geneva, Wis 53147

Oct 2-3: *Selected Problems in Pediatric Neurology*, Dept of Neurology, The Medical College of Wisconsin, Milwaukee Children's Hospital, Milwaukee. Info: Jennie M Evenson, tel: 414/931-4074.

Oct 14: *Wisconsin Radiological Society*, The Concourse, Madison, Wis 53701

Oct 16: *Milwaukee Academy of Medicine*, University Club of Milwaukee, Milwaukee, Wis 53202

Oct 27-28: *Wisconsin Chapter, American College of Emergency Physicians*, Red Carpet Inn, Milwaukee, Wis 53202

Nov 3: *Pediatric Emergencies*, Fall Pediatric Day, Wisconsin Chapter, *American Academy of Pediatrics*, Wisconsin Center, Madison, Wis 53706

Nov 18: *Wisconsin Dermatological Society*, Milwaukee County General Hospital, Milwaukee, Wis 53202

1978 NEIGHBORING

Sept 7-11: *Medical Knowledge Self-Assessment Program Course*, Towsley Center, Ann Arbor, Mich. Info: Registrar, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Sep 21-23: *Solving Difficult Problems in Ambulatory Pediatrics: A Multidisciplinary Approach*, First Annual Department of Human Development Seminar, College of Human Medicine, Michigan State University, at The Kellogg Center for Continuing Education, MSU. Contact: Conferences and Institutes, 50 Kellogg Center, MSU, East Lansing, Michigan 48824. p7/78

Sept 26-30: *Medical Knowledge Self-Assessment Program Course*, Mayo Civic Auditorium, Rochester, Minn. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

Oct 10-14: *Medical Knowledge Self-Assessment Program Course*, Ambassador West Hotel, Chicago, Ill. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa

Oct 21-25: Annual Convention, Indiana State Medical Association, at Marriott Inn, Clarksville, Ind 47130

1978 OTHERS

Sept 18-21: *Pulmonary Medicine—An Update for the Clinician.* American College of Chest Physicians, The Mark Resort, Vail, Colo.

Sept 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

Aug 7-Sept 3
Edema: Causes and Treatment, with George A Porter, MD, Chairman, Dept of Medicine, University of Oregon Health Sciences Center, School of Medicine, Portland. An increase in the extracellular fluid compartment signals a disturbance in sodium retention and can pose a serious threat to your patient. During this telecourse, the viewing physician will have an opportunity to participate in the management of two challenging outpatient problems. In addition, you will observe the proper emergency management of patients with pulmonary edema. This three-part program outlines the pathogenesis of generalized edema associated with congestive heart failure, nephrotic syndrome, and cirrhosis. Dr Porter focuses on the mechanisms that cause edema and provides a rational basis for selecting a diuretic agent that acts at the specific segment of the kidney that is malfunctioning.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

1979 WISCONSIN

Feb 13-14: Wisconsin Chapter American College of Emergency Physicians, Alpine Valley Resort, East Troy, Wis.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835. ■

SMS MEMBERS
use the
IN- "WATS"
toll-free number
1-800-362-9080
to reach staff
at SMS headquarters
in Madison

FAMILY MEDICINE

Topic: *Primary Care—A View Toward the 80's*

Aug 17-19, 1978

Interlaken Lodge/Villas,
Lake Geneva, Wisconsin

For: Family Physicians, Internists and Pediatricians, 3 one-half days conference. 15 hours of instruction; CME Credit Category I AMA.

Fee: $80.00

Sponsored by Department of Medical Education, Ravenswood Hospital Medical Center, 4550 N Winchester at Wilson, Chicago, Ill 60640.

Contact: Mara Harrington, Secretary

Telephone: 312/878-4300

6-7/78

American Society of Internal Medicine Future meetings:

Sept 26-29, 1978	Interim Meeting	Orlando, Florida
April 26-29, 1979	Annual Meeting	New Orleans, Louisiana
Sept 28-29, 1979	Interim Meeting	Las Vegas, Nevada
May 15-18, 1980	Annual Meeting	Washington, DC
Sept 26-27, 1980	Interim Meeting	San Diego, California
April 30—May 3, 1981	Annual Meeting	Denver, Colorado

CONTRIBUTIONS—CES FOUNDATION May 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1978.

Unrestricted

Anonymous; Dane County Medical Society Auxiliary; Fond du Lac Medical Society Auxiliary; Pierce-St Croix County Medical Society Auxiliary; Marathon County Medical Society Auxiliary; Brown County Medical Society Auxiliary; Eau Claire-Dunn-Pepin County Medical Society Auxiliary; Winnebago County Medical Society Auxiliary; LaCrosse County Medical Society Auxiliary; Robert B Murphy—*Voluntary Contributions*

Restricted

Outagamie County Medical Auxiliary—*In Appreciation of Sally Mielke-President State Auxiliary*
RH Siedenburg, MD; Surgical Care Blue Shield—*Medical Student Summer Externship Program*
Membership Dues—*Aesculapian Society*
County of Crawford; LaCrosse County Medical Auxiliary—*Museum of Medical Progress*

Memorials

State Medical Society—*Nat Goldberg, MD; EA Bryezenski, MD; Peter A Midelfort, MD*
Eau Claire-Dunn-Pepin County Medical Society Auxiliary—*Mrs. Elizabeth Manz* ■

HEW BLOCKED IN RELEASING T-18 PHYSICIAN LIST

The American Medical Association was granted a temporary restraining order in June preventing the Dept of Health, Education, and Welfare's release of the list of physicians who received Medicare payments in 1977. The suit, filed by the AMA against HEW Secretary Joseph Califano, charges that publication of the list would invade the statutorily recognized interest of each physician in the confidentiality of information relating to personal income, would call into question the integrity of physicians, and would deter physicians from treating Medicare beneficiaries in the future.

AMA CME/GOLF PROGRAM PLANNED FOR FLORIDA

The AMA Sports and Recreation Program will hold its Third Annual Program in conjunction with the Golf Digest Instruction Schools, at the Doral Country Club in Miami, Florida on October 29-November 4. The six-night, five-day activity includes an active clinical program with courses in continuing medical education and individual instruction in golf. Physician members of the AMA will have an opportunity to earn 6 hours of Category 1 credit and 6 hours of Category 2 credit towards the AMA Physician's Recognition Award through attendance at the seminar on "Practical Rheumatology" (Category 1) and "Enhancing Your Financial Skills" (Category 2). Further info: AMA, 535 N Dearborn St, Chicago, Ill 60610.

PRE-AMA REGIONAL CME MEETING ACTIVITIES SET

Golf, tennis, sightseeing, and social activities are scheduled for AMA-member physicians and their spouses immediately prior to the AMA Regional CME Meeting (September 8-10) on September 4-7 at the Williamsburg Lodge, Williamsburg, Va. Further info: AMA Sports and Recreation Program, 535 N Dearborn St, Chicago, Ill 60610; call: 312/751-6057. Reservation deadline: August 15.

WISCONSIN NEWSPAPERS SHOW INTEREST IN 'HEALTH CARING'

During its first month, the SMS Communications Department's "Health Caring" column, authored by Victor S Falk, MD, medical editor of the *Wisconsin Medical Journal,* has been picked up by about 30 Wisconsin daily and weekly newspapers. The weekly health column offers suggestions on how to stay healthy and maintain positive lifestyles. Why not check and see if your local paper is running the column, and if it isn't, urge the editor to consider using it.

PLAN ON ATTENDING SEMINARS FOR FAMILY PHYSICIANS

Physicians should mark September 20, October 18, and November 15 on their calendars now, since those are the dates of the 1978 "One-Day Seminars for Family Physicians" in Green Bay. The SMS Commission on Continuing Medical Education again is sponsoring the seminars which qualify for Category I credit for the Physician's Recognition Award of the American Medical Association. The seminars will be held in Green Bay on Wednesday, September 20, at Bellin Memorial Hospital; Wednesday, October 18, at St Vincent Hospital; and Wednesday, November 15, at Bellin Memorial Hospital. For more information, contact the Quality Care Division at SMS office in Madison. ▪

STATE HEALTH PLAN IN REVISION PROCESS

The Plan Developing Committee of the Health Policy Council (HPC) continues to revise the diagnostic and treatment sections of the State Health Plan during the summer months. The Committee will be revising those sections of the Plan relating to: mental health services, obstetrics, radiology, general medical services and surgery. The sections, as amended by the Plan Developing Committee, will all go to the Health Policy Council for final approval in October. (See the IN PERSPECTIVE section of this issue for an overview of the State Health Plan by HPC chairman, Dr Ben Lawton.) Physicians may obtain copies of any section of the Plan as revised by the Committee by contacting the SMS Quality Care Division. In addition, any physician who is interested in working on a Health Policy Council committee to work on writing and revising planning documents should contact the SMS Quality Care Division at toll-free 1-800-362-9080.

CERTIFICATE-OF-NEED FORMS READY

The SMS Quality Care Division has received "notice of intent" and formal application forms for the Certificate-of-Need (CON) process from the Bureau of Needs Review. Any physician considering purchase or lease of clinical equipment costing $100,000 or more for one piece, or $150,000 or more for two or more pieces of equipment, should file a "notice of intent" form with the local health systems agency and the State Division of Health. These agencies will then send the physician a formal CON application form. Physicians with questions concerning the CON process or the forms involved should contact the SMS Quality Care Division at (toll-free) 1-800-362-9080. In particular, those physicians currently going through the CON process and have suggestions for changes in the forms should inform the SMS Quality Care Division which will in turn communicate these suggestions to the Bureau of Needs Review.

BLUES TO OPERATE SECOND-OPINION PROGRAM IN WISCONSIN

The Wisconsin Physicians Service in Madison and Surgical Care in Milwaukee will operate the Medicaid-Medicare second-opinion program in Wisconsin starting September 1, 1978, the Department of Health, Education, and Welfare has confirmed. Under this program each Blue Plan will solicit physicians who are willing to provide second opinions on elective surgical procedures for T-18 or T-19 patients and will maintain lists of those physicians. They will offer a toll-free service to patients who wish to obtain second opinions, providing the names of physicians from the list. This fall HEW will launch a massive nationwide television-radio-newspaper campaign to encourage the public to use the second opinion referral process.

PHYSICIANS: COMMENT ON COMMUNITY HEALTH SERVICES ACT

The Environmental and Public Health Committee of the Health Policy Council is in the process of developing a Community Public Health Services Act for Wisconsin. The Act represents a major restructuring of all public health services in Wisconsin and purports to give more control to local communities and county boards in public health planning and administration. The Committee, composed of consumers and public health professionals from all parts of the state, would appreciate physician input and comments on this proposal. Copies of the proposed act along with a questionnaire for physician comments are available by contacting Neal Neuberger, Health Planning Analyst, SMS Quality Care Division, in Madison. On September 14, the Committee will meet to review comments submitted by interested parties before preparing the final draft of the Community Public Health Services Act. ■

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN MEDICAL JOURNAL
1903 1978 75th ANNIVERSARY YEAR

Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues); non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Position Available: Requires a thorough knowledge of tax laws, real estate, accounting procedures, insurance, finance and investments. Candidate must be able to collect and inventory all property, have all property appraised, collect income and rents, carry appropriate insurance, contest all claims believed invalid, pay all expenses, render accurate accounts and make distribution under court approval. Must be impartial. Should be willing to work long hours and accept risk of personal financial liability for errors.

Does your executor qualify?

Today, an executor's job is hardly honorary. Besides time-consuming legal and administrative duties, the 1976 Tax Reform Act imposes new responsibilities.

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A peek at the survey

LAST APRIL THE results of the September 1977 Physicians' Opinion Survey conducted by the Physicians Alliance Commission were submitted to the Council. There was a 54.5% response from our membership. Many took the trouble to write in appropriate comments, some of them repeated over and over again, developing a sort of recurring theme, part of which will be recounted below.

As might be expected, several expressed wonder and grudging admiration for the chiropractors' political moxie, but continued to hold their craft in disdain. There did not appear to be any ground-swell of opinion to join the chiropractors, however.

Many members wrote of their concern over loss of image and our inability to police ourselves and discipline the bad apples. There is definitely a sense of urgency to move ahead in that area.

Several indicated feelings that the employed or hospital-based physicians were not being fairly represented by Society leadership. If this is true, it is unintentional, but must be rectified. This sense of isolation felt by the hospital-based physicians and by faculty people could well account for the recent membership attrition in those fields.

Another group which expressed a sense of frustration due to lack of representation were the rural physicians. A typical quote: "Life in the woods—I really feel that the state government in particular and physicians in the remainder of the State Medical Society in general don't care if we sink or swim."

Surprisingly, many responders admitted lack of understanding of the meaning of the initials HSA (Health Systems Agency). This is almost inconceivable, and means that many of our members don't read their mail, or even the newspapers, and portends a rather hard time for those of us who are given the responsibility of keeping Society members informed. It is extremely unlikely that we can ever function as a unified organization if we are unable to communicate with each other.

These are just a few of the more outstanding examples of areas of concern. There are many more which will offer Society leadership grist for its various mills. Generally, among those writers who were obviously well informed one could detect a willingness to get out of our conventional rut and become innovative instead of traditionally reactionary. There also seemed to be a desire to hold the line on fees—at least among those who took the trouble to comment. This is encouraging, and could, if implemented, enhance that image so many seem to be so worried about.

But we all have to be disturbed by the obvious ignorance of society activities and health-care matters exhibited by the rank and file. If this is truely representative of the American physician, we will be eaten alive in the years to come.—WJB

Lessons in dying

MAYBE IT'S BECAUSE of the uncertainty of the times; maybe it's our guilty consciences, but we seem to be placing an inordinate emphasis on death and dying the past year or so. The topic is beginning to appear on programs at medical meetings and is discussed by nursing, administrative, and paramedical personnel as well.

The thrust seems to be that when hope for cure is gone, the shift toward easing the patient off this mortal coil should occur sooner and more openly. In other words when you give up on chemotherapy or the antibiotics, you should spend the remaining time teaching your unwilling subject how to die gracefully and (as they always say) "with dignity."

There are some problems with this approach. First of all it isn't always easy to define that point when hope is gone, and often the physician and family disagree. And even if they do reach a meeting of the minds, the patient may well have ideas of his own and quash the whole thing.

For the sake of discussion, though, let's assume all are in agreement and the order goes out: "Teach the patient how to die." Who will do the teaching? A nurse? A psychologist? A social worker? A chaplain? The doctor? If I were the prospective pupil I'd say: "Send in someone who's been there, or leave me alone."

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The patient who actually is dying knows more about death and dying than the misguided creatures who will instruct him. Sometimes the patients teach the teachers a great deal. For example, one morning a few weeks ago, an internist and I were telling a long-time friend of ours who had terminal malignancy that we had exhausted our resources and were throwing in the sponge, and we wanted his permission to curtail some of the measures that were prolonging his misery. He smiled and said he'd like to think it over and pray for a few hours that afternoon before making his decision. The internist then remarked that our patient and my wife were the only two people he knew who seemed to have a direct phone line to the Lord—whereupon our terminal patient said to me: "Tell your wife to stay off the line today, will you?"

The point is our friend already knew how to die. If one has led a useful, productive life and has strong family support, dying is a natural event with a minimum of disruption and requires no instruction. If one's living has been less than satisfactory, dying won't be very smooth either, and taking a course in it can only end in another failure.—WJB ■

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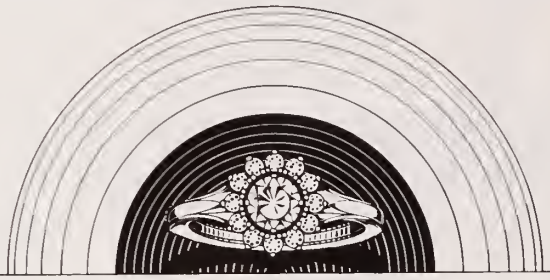

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LETTERS

Insect sting kit

To the Editor: In preparation for a September meeting of the National Institute of Allergy and Infectious Diseases to consider the feasibility and advisability of making the insect sting kit available to certain trained categories of medical and lay persons, without a specific prescription by a physician, I would be interested in receiving information and comments by the reader of this journal on the following questions:

1. Have you any knowledge of a fatal reaction to an insect sting or drug or food? If so, I would appreciate as much detail as possible, including information concerning the time interval between contact with the offending agent and death.
2. If you know of such a fatality or fatalities, in your estimation, would an immediate subcutaneous injection on the scene of a premeasured dose of epinephrine 1:1000 (0.3 cc to 1.5 for adult, 0.2 to 0.3 cc for children) have afforded a different outcome?
3. Have you any knowledge of adverse effects of subcutaneous injections of epinephrine 1:1000 in the above dosages? If so, again I would appreciate as much detail as possible.

We would certainly appreciate any information you can supply.

CLAUDE A FRAZIER, MD
Doctors Park/Bldg 4
Asheville, NC 28801

July 7, 1978 ■

Letters to the Editor are welcomed and will be published for information and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, Box 1109, Madison, Wisconsin.

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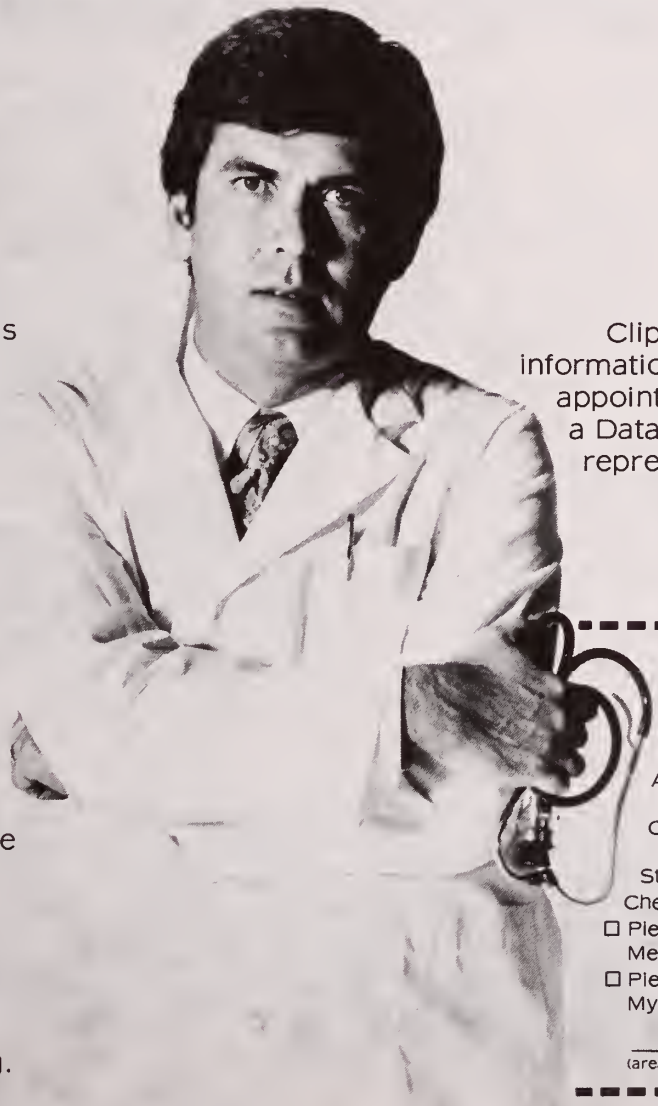

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NEWS YOU CAN USE

JAIL HEALTH CARE FILM WINS AWARD

The AMA film, "Out of Sight, Out of Mind," which examines medical care problems in jails and the progress made in solving them through the Jail Health Project, took top honors in the medical sociology category at the John Muir Medical Film Festival at Walnut Creek, Calif. The 22-minute film, produced and directed by Robert Martin of the AMA's Audiovisual Services Dept, is available on a free-loan basis to state, county, and specialty medical societies. For information write Audiovisual Services, AMA headquarters, 535 N Dearborn, Chicago, Ill 60610.

RURAL HEALTH CARE DISCUSSED IN NEW BOOKLET

Crossroads to Health Care, an informational booklet explaining the alternatives open to small communities in obtaining health care delivery is available on request to all Society physicians. The booklet was funded by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. There is no charge for up to five copies distributed to physicians residing in Wisconsin. For more than five copies, a one dollar fee is charged per copy. To order, contact Arlene Meyer, Quality Care Division, at SMS offices in Madison.

AMERICAN EXPRESS ENTERS MEDICAL FIELD

American Express recently began notifying its cardmembers that the Card is accepted at more than 145 medical facilities throughout the United States and Canada. The hospitals and medical centers were specially selected to be near places where most people travel, according to the company. Maurice Segall, president of the Card Division, said: "This is one time we hope our cardmembers won't have to use the card. However, we believe it is comforting to know that they can receive outpatient or emergency medical attention without delay or redtape." American Express expects to expand the service to include other hospitals and medical centers within the United States and other major cities around the world in the future. ■

Health & Planning Delivery

PART I: Interview with Dr Ben Lawton

by JON SOFFER

THE FOLLOWING interview with Dr Ben Lawton, chairman of the Wisconsin Health Policy Council, is the first of a two-part series examining the final draft of the 1978 State Health Plan. Affecting virtually every facet of medical practice, the Plan is an attempt to strengthen both the role of planning in health services delivery and consumer input in state health management.

It contains numerous goals, objectives, policy recommendations, and resource requirements many of which have been subject to harsh scrutiny and substantial criticism from all sides of the health spectrum.

In January 1978 the Health Policy Council (HPC), the chief policy-making body in the State, voted to release a draft of the highly-debated Plan for review and comment at public hearings. Hundreds of physicians and allied health providers testified at the hearings and recommended substantial revisions of the Plan. In response, the HPC revised many of its sections. A vote on final approval of the revised State Health Plan is expected at the Health Policy Council's August 24-25 meeting.

In 1971 Dr Ben Lawton of Marshfield was appointed vice-chairman of the Governor's Health Planning and Policy Task Force. Also since 1971 he has served as chairman of the Health Policy Council and plays a leading role in the development and coordination of health planning activities.

Doctor Lawton, this year, received the State Medical Society's Council Award, the highest award bestowed to its doctor members. In addition to his professional achievements, Doctor Lawton is well-versed on the political and fiscal implications of health planning as evidenced by his chairmanship of the most important health planning and policy-making body in the State, the Health Policy Council.

The *Wisconsin Medical Journal* assigned Jon Soffer, a University of Wisconsin-Madison medical journalism student interning this summer with *WMJ*, to interview Doctor Lawton in his office at the Marshfield Clinic. The interview follows:

Q. Doctor Lawton, what is your opinion of the current health status of Wisconsin citizens?

A. There is known to be a wide variation of health status from community to community in Wisconsin, such as the defects in our health system in the Menominee reservation and inside Milwaukee's inner core. The delivery system is inadequate there. But speaking in overall broad terms, the health status is pretty good in Wisconsin, with room for much improvement.

Q. Do you think a state health plan is necessary in Wisconsin?

A. Yes.

Q. Do you think state government should share the costs of public health services?

A. Definitely. Health is a recognized and justifiable expenditure in public funding.

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Q. According to Public Law 93-641, the Health Plan should be composed with input from the State's seven health systems agencies, more commonly referred to as HSAs. What are HSAs, and do these locally-situated agencies actually have a substantial input in state health policies?

A. HSAs are regionalized agencies that discuss and plan that area's specific health issues. The origin of your question stems from some complaints that the HSAs have not had adequate input and this was recognized after the January HPC meeting. Now they have had more input and an increased understanding of what the future will hold as far as input is concerned. It is a mistake to feel that the Wisconsin State Health Plan is just a compilation of the seven HSA plans. That would be overly cumbersome. Locally, hopefully, the State Plan will not have any major deviations from what the HSAs propose. If the plan is reviewed periodically as we interpreted it would be, there'll be ample opportunity for discrepancies to be ironed out.

This State Health Plan has not been revised since 1975, the same year Public Law 93-641 was passed. When that law was passed, it probably set back health planning in Wisconsin two years. This is a result of the fact that we were way ahead of the game under the old law (Comprehensive Health Planning Act of 1966). Then Congress changed the law, forcing development of new membership of agencies such as the HPC, new composition of the HSAs, and we had to also go through the designation process of HSAs. This really slowed the entire process down by at least two years.

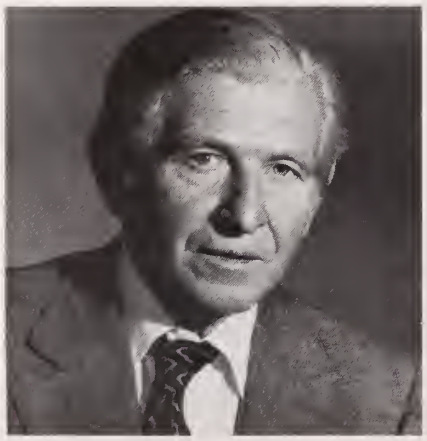
I think the HSAs are contributing input to the best of their ability. I received enough local plans to know that they are doing just that, even though they are under-funded to accomplish this input on an ongoing basis.

Q. Do physicians have a substantial voice in the Plan?

A. I deplore the little input that the physicians have had in that original plan — it's only slightly better in the current, revised plan. But it's a great credit to the State Medical Society that there has been considerably more physicians' input in technical committees within the last few months. Prior to that there was way too little effort at the beginning of the drafting of the Plan. Misinformation, obvious the first time over, had been pulled out of previous writings — mistakes not obvious to the laymen. The people who did the writing did not realize that some of the things they were expressing were highly controversial and perhaps even in error. It was quite obvious that the first go-round needed the help of technical committees to review the unchecked material.

Q. Do you think it is possible for the Plan to achieve its goal of "widespread, adequate, and inexpensive health care?"

A. If you don't accept that as a goal, we're all wasting our time. I don't think we can state it in such a positive way that this Plan will do those things because there are so many factors involved. This Plan will ideally organize health providers to get together in such a manner that we will eventually have a blanket coverage of health services, hopefully on an economical level. Good medical care is expensive as hell and will continue to be expensive. "It is worth the price we're paying" is an answer that we're looking for — to date the American public has been



Ben R Lawton, MD *. . . a practicing general and thoracic surgeon at the Marshfield Clinic since 1954; served as the Clinic's president for six years, 1969-71, 1975-77. Besides his chairmanship of the Health Policy Council and membership in over 13 professional and medical socities, Doctor Lawton holds several other administrative positions, including a position on the University of Wisconsin System Board of Regents and the Council of Trustees for the University of Wisconsin Hospitals. He is a past president of the State Medical Examining Board. Doctor Lawton also has served on the State Medical Society's Commission on Scientific Medicine and the Division on Chest Diseases.*

I deplore the little input that the physicians have had in that original plan — it's only slightly better in the current, revised plan. But it's a great credit to the State Medical Society that there has been considerably more physicians' input in technical committees within the last few months.

willing to pay for adequate medical care. I don't see there being a great demand for cheap medical care because cheap medical care is not going to be good medical care.

Q. This is a quote taken from the opening paragraphs of the Plan: "For medical services, no one has been able to show a necessary connection between their availability in a community and that community's health status." Do you have any comments?

A. That quote reflects a popular opinion of statisticians who are indeed counting deaths and lives. For the parameters that they measure, the availability of services many times does not reflect any great impact on health in a community. As an active physician-surgeon, associated with many other active physicians, I know there are literally hundreds of lives saved by physicians. And while the data they use to prove this broad remark may be reliable, it doesn't mean a damn thing to the poor individual who would die without us. He's 100 percent dead, so the data would be meaningless.

Q. What do you see as the principal long-range and short-term benefits of the Plan? Disadvantages?

A. Most of the impact of the Plan will not and cannot be implemented right now — we're talking 5 to 10 years in projection. A major disadvantage is that the Plan does take so long to become effective — maybe that's an advantage, providing more time for careful analysis. The process — writing it, getting it approved by all those who should be involved, then implementing it through the innumerable bureaucratic hoops that are necessary — at best seems to a poor physician an extremely slow process. An advantage is the potential successful programing this Plan could bring to the delivery of health services throughout the state.

Q. There is a recommendation in the Plan to "achieve a goal of reducing deaths from accidents and violence to a rate of 55 per 100,000 population." Should homicides and violence be part of a State Health Plan?

A. Too many times homicides, traffic deaths, and violent deaths are caused by alcoholism, drug abuse, or other health-related dysfunctions. Through an improved health environment, a State Health Plan can substantially improve and reduce homicides and related violent deaths.

Q. How, if at all, can this health plan be successfully implemented?

A. I don't think it is anticipated that the whole three pounds of it will be implemented next January. We will be trying to list and prioritize considerations of what should be done first. This will necessarily require more exacting fiscal notes. I think it will be successfully implemented by the combined efforts of peer review, executive action, by the Governor and his appointees to the DHSS, by legislative action, and by public and local action. There is a wide spectrum of implementers — some at the local level, some at the State Medical Society, some at the Hospital Association. Their combined efforts will make this Plan go.

Q. Regionalization of health services, such as those proposed in the heart disease section of the Plan, seems to be the sign of the future in medicine. Comments?

A. That pattern is becoming a trend but is not necessarily a sign of the future; it simply is developing now, the private sector being the main impetus. The relationship between smaller hospitals and clinics are examples of this regionalization carried out by the private sector. If imposed by the State, it is liable to be hastened some by the added push, such as the present certificate-of-need program.

Q. There is a goal contained in the Plan that calls for a 20 percent increase in ambulatory surgery. Isn't the place of surgery more appropriately decided by patients' needs than by

I would not let any planner tell me that I should be doing my hernia operations as outpatient procedures.

an arbitrary percentage plan of a state agency?

A. I, as a surgeon, decide strictly what is best for my patient. There are certain things that some surgeons do as an outpatient procedure that I will not do. If he does not feel easy doing the best thing for his patient, no matter what the hell the book says, he shouldn't do it. The intention of the Plan is to draw attention to the possibility of saving some money by outpatient surgery. I feel even more strongly that we should head off any proposals to have outpatient surgical centers as such. It's just a license to make money. The existing hospitals have the staff and facilities to operate 24 hours a day. These surgical centers do not. When these centers are through at 6:30 pm, they send the patients home or to the hospitals.

We should point up the desirability of outpatient surgery and encourage hospitals to promote it. Also, we can educate surgeons within certain limits of how to do the best things for their patients with outpatient surgery. There is a wide variation of opinion on this point. I would not let any planner tell me that I should be doing my hernia operations as outpatient procedures. I've done hundreds of them and I find that just now and then there's a damn good reason for that patient to be in the hospital at night — such a good reason that I am not going to put any patients through it. Some people would; I won't.

It is a mistake to feel that the Wisconsin State Health Plan is just a compilation of the seven HSA plans.

Q. The State Medical Society has commented that the Plan editorializes too much and doesn't knowledgably deal with specific medical services. Comments?

A. The State Medical Society legitimately cried "wait" when the Plan first came out for various reasons. They did it very justifiably so, and they got results by appointing technical committees to help in writing some of the factual contents. Editorializing, I don't get quite as excited about it as the councilors of the Society and other physicians. I don't think it's all that harmful.

Q. Do you think this planning process will be altered with a change of leadership in state government?

A. No. Whichever one of the four gubernatorial candidates wins, I don't foresee any changes. The fact remains that what we're doing is mandated by federal law and the implementation is liable to be more in the hands of the Legislature than the Executive Office, except for a few appointees. I don't think that any of them would be opposed to the efforts we're making.

Q. How can one assure the HSAs of substantial power and influence in the development of state health policy?

A. The Health Policy Council is one way to assure local HSA input because the representatives from all of the HSAs are there by law. They are very vocal when things come up that touch on their territory. They let us know about it.

Q. The final section in the Plan — the Enabling Services area — recommends a goal to strengthen the HPC's role in directing State health policy by extending the review period and applying an overall increase in that Council's powers. Do you have any comments on this recommendation?

A. It might not be appropriate for me to have too strong an opinion on it. We can have a very effective role. We don't legislate. We don't have any clout except for recommendations. The government respects our opinion. There is room for strengthening our role because the Council is made up of a large number of extremely devoted, hard-working citizens, most of whom are not providers.

Part II of this special feature on Health Planning and Delivery will be an interview with Dr John Peters, a family practitioner of Fond du Lac and a member of the Health Policy Council.

The JOURNAL encourages replies or comments from interested readers. ■

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Cancer epidemiology

Part III

Cervical cancer

In the United States mortality from cervical cancer increases continuously until at least age 70. For all ages the mortality rate among whites has been declining since the early 1950s and for nonwhites for the past 10 years. The age-adjusted nonwhite mortality rates are approximately two times that of whites. Only Douglas County in Wisconsin has a mortality rate significantly above the national average.

By contrast the incidence rates for cervical cancer are two to three times greater than the corresponding mortality rates. The total incidence rises to a peak in the mid-thirties and then declines. This marked difference in incidence and mortality largely reflects the age distribution of in situ carcinoma which accounts for most cases until the late 40s.

Differences in annual incidence rates have been noted between countries, ranging from a low of 5.4 per 100,000 in Israel to a high of 90 per 100,000 in Manitoba, Canada.[1] Some difficulty in determining the true extent or trend in incidence rates has resulted from the widespread introduction of cytological screening programs which tend to increase the number of in situ cases diagnosed. Many of these may never become invasive so would never be reflected in mortality rates.

In studying the cost/benefit effectiveness of large scale cytological screening programs, the percentage of in situ cervical carcinomas that eventually become invasive (0-61.5% depending on the study) was examined.[2,3] Studies of examiner variability in classifying cytological specimens revealed an average agreement of only 54%;[4] most of the disagreement occurred in slides classified as carcinoma in situ, microinvasion, or atypical squamous hyperplasia. Although most studies have supported mass cytological screening to detect cervical cancer, the target population, screening frequency, and program effectiveness have been disputed.

Many studies have pointed to the roles of coitus, marriage, and pregnancy in causing cervical cancer. Cervical cancer victims have been found to have a higher relative frequency of early coitus; perhaps the biologically immature sexual organs are more sensitive to carcinogens that are transmitted venereally. Compared to women without cervical cancer, these patients more frequently have had multiple coital partners and report more broken marriages, remarriages, separations, divorces, and multiple marriages. Also their husbands more frequently have had extra-marital sexual partners. Married women with cervical cancer also tend to have married earlier, been pregnant more frequently, and had their first pregnancy at an earlier age.[5,6] Other studies have associated the disease with lower socio-economic status, less education, and failure to use contraceptive devices compared to the controls. Blacks have four times the disease incidence rate of whites.

Attempts have been made to associate the markedly decreased risk of cervical cancer among Jewish women with the prevalence of circumcision among Jewish men.[7] Results of studies on the circumcision status of partners of women with cervical cancer have varied.

Both syphilis and trichomoniasis infections have been linked with cervical cancer; however, it is generally accepted that this association is secondary, resulting from the relationship of both diseases to venereally transmitted factors.[8] Recent studies have shown a higher than expected level of antibodies to herpes virus HSV-2 in patients with cervical cancer, suggesting a possible etiological link.[9] Gonorrhea, chronic inflammation of the cervix, bleeding, spotting, and vaginal discharge may also increase the risk.

To test the hypothesis that venereal factors operate in human cervical cancer, a study was undertaken to determine if the risk of developing this disease was increased among the wives of men who had been married at some time to other women who also developed the disease. Preliminary evaluation of the data has revealed a 3.5 times greater than expected incidence among these subsequent mates.[10]

A commonly accepted hypothesis linking many of these epidemiological findings is that males carry a chemical carcinogen, presumably in smegma, which causes cervical cancer. Those factors which relate to increased frequency of intercourse or exposure to smegma, therefore, would be increased in patients with the disease.[11] (To be continued)

References may be obtained by request from the Wisconsin Clinical Cancer Center.

—Jane Harberg
Dorothy J Buchanan-Davidson, PhD

continued next page

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman, SMS Committee on Cancer. Box 1109, Madison, Wis 53701.

Supported by NCI Grant No. 5 R18-CA-16405-03.

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Colposcopy cures cervical cancer

About 20,000 new cases of cervical cancer are diagnosed in the United States annually. The Papanicolaou (Pap) smear—a simple, accurate (95%), and inexpensive procedure—is used extensively to detect and treat preinvasive and invasive cervical cancers. To follow all Wisconsin women found to have suspicious or abnormal Pap smears, a Wisconsin Colposcopy Network consisting of clinics in Milwaukee, Madison, LaCrosse, Marshfield, Appleton, Eau Claire, Stevens Point, Green Bay, and Ashland was established in 1974, with Dr Adolf Stafl of the Medical College of Wisconsin as director.

A colposcope which magnifies the cervical epithelium 16 to 20 times permits diagnosis of unsuspected cervical carcinoma in situ, improves diagnostic accuracy, differentiates between inflammatory atypia and cervical neoplasia, permits localization and diagnosis without trauma, and reduces the need for diagnostic conizations. Excisional biopsy can often remove the diseased elements. Frequently cauterization is not necessary. Dysplasia can often be treated with cryosurgery or cautery. However, if the lesion appears to be more than carcinoma in situ, shows vascular changes due to microinvasive disease, or is frank invasive carcinoma, a conization should be done.

Colposcopic examinations cost about $100, are safe yet painless, and can be done on an outpatient basis, compared to conizations which cost about $800, require several days of hospitalization, and cause considerable morbidity. In one year the Colposcopy Network reduces the number of conizations done on Wisconsin women by about 1000, thus saving Wisconsin citizens about $700,000 and avoiding the morbidity associated with conizations or advanced cervical cancer.

—Dorothy J Buchanan-Davidson, PhD

DATES TO REMEMBER

Sept 29: Wisconsin Oncology Group, will discuss Cancer of the Testes, Kidneys, and Lungs.

Sept 30: Fall Cancer Conference. For program and registration details, see the Yellow Pages section of this issue.

Oct 12: Regional Cancer Conference. See details in yellow pages section of this issue. ■

Phencyclidine overdose: an emergency concept of management

"Angel dust" is susceptible to "ion trapping" and that is good news to overdose victims of phencyclidine (PCP), says the American College of Emergency Physicians.

"Ion trapping" is a treatment technique described in "Phencyclidine Overdose: An Emergency Concept of Management," in the February issue of *JACEP*, the medical journal for emergency medicine. The authors, Regine Aronow MD, Alan Done MD, and Joseph N Miceli PhD, developed the treatment to deal with the rising incidence of "angel dust" overdoses seen at The Children's Hospital of Michigan in Detroit.

Phencyclidine is found on the street in a variety of pill forms, capsules, dust and occasionally as a liquid. It is sniffed, smoked or swallowed. Often, it is represented to buyers as mescaline, cocaine, amphetamine or LSD. Victims of overdose may suffer loss of tactile sensation, coma, convulsions and respiratory failure.

Chronic users often arrive in the emergency department with psychiatric problems including acute anxiety, severe depression and paranoid psychosis. With few references in the literature on the management of PCP, there has been little guidance available for physicians faced with a victim of PCP overdose.

The illicit use of PCP, developed in the late 1950s as an anesthetic for nonhuman primates, is fast becoming a nationwide problem. The National Institute of Drug Abuse estimates that as much as 30 percent of all admissions to mental hospitals may be PCP-related. In Michigan alone, over 360 deaths were caused by PCP overdose in the past three years.

Doctor Aronow's treatment removes the drug from the victim's body as fast as possible by washing out the stomach and increasing the acidity of the urine which facilitates "ion trapping." In ion trapping, the acid medium forced into the patient's stomach through a tube is absorbed, and attracts the PCP ions already in the body's system like a magnet. Because acid is not reabsorbed into the body, the trapped PCP is flushed out of the body through the urine.

Doctor Aronow uses ammonium chloride and ascorbic acid, dissolved in saline as the acid medium. The rate at which the patient recovers is directly related to the amount of PCP taken from the body.

Once a patient regains consciousness, ascorbic acid is continued throughout the hospital stay. The patient is also encouraged to drink several glasses of cranberry juice a day. The juice has a high acid content, and continues the acidification program.

The treatment also involves support measures and close monitoring of vital signs. While the victim should be in a quiet, low-light environment, "talking down" is of no use in handling these patients.

In the group of patients studied, this approach to treatment was successful in all cases, including one who had been on respiratory assistance for nine days before the treatment was begun. Patients recovering from extreme overdose show a steady pattern of continuing improvement, unlike the uneven progress shown by the patients who received only supportive care.

JACEP is the monthly clinical journal of the American College of Emergency Physicians and the University Association for Emergency Medicine. These organizations represent over 9,000 emergency physicians working to improve the delivery of emergency health care throughout the United States by developing standards and methods for the professional practice of emergency medicine. ■

Justice Department may review Title 19 records

A recent contract signed by the Wisconsin Department of Justice and the Wisconsin Department of Health and Social Services establishes the protocol for the activities of the Medicaid Fraud Unit in the Attorney General's office.

A key element of that contract directs the two agencies to make arrangement for the Justice Department unit to obtain records on services provided to Medical Assistance—Title 19 recipients by provider from DHSS. The Medical Assistance Program generally allows the Department of Health and Social Services to have access to such records; this contract for the first time specifically allows another state agency to also have access to the records.

The SMS Physicians Alliance has been in touch with DHSS Secretary Percy to determine what system of record referral to the Justice Department will be utilized.

It is important for physicians to know that, at least for the present, Justice Department attorneys in the Medicaid Fraud Unit may be reviewing their Title 19 records retained by DHSS. Any clarification the Alliance receives from Secretary Percy will be communicated.

In the meantime, in the event a Justice Department representative asks to see T-19 patient records, the physician is advised to take reasonable steps to assure unimpaired protection of his/her legal rights by:

(1) verifying the identification credentials of the investigator,

(2) requesting the advice of an attorney *before* turning over records, or

(3) contacting the State Medical Society for advice.

Physicians interested in more information should contact the SMS Physicians Alliance Division at 608/257-6781 or toll-free at 1-800-362-9080. ■

Extended jail health accreditation awarded to Eau Claire

The Eau Claire County Jail is one of four county jails in the nation to earn a two-year, full accreditation from the SMS-AMA Jail Health Care Project. This year, for the first time, a jail could receive a two-year accreditation provided that it was in full compliance with the necessary health and medical care standards for jails established by the Project.

One of three original pilot sites in the project since its inception in 1976, the Eau Claire County Jail received a one-year accreditation last August.

Through the combined effort of the Eau Claire County Jail officials, State Medical Society of Wisconsin physicians and staff, and other health-care providers, the Eau Claire County Jail has been a leader in establishing necessary health and medical care services for jail inmates in Wisconsin. ■

Changes proposed to medical malpractice laws

The State Judicial Council has proposed adding discovery, concealment, and foreign object provisions to the State's laws affecting medical malpractice for adults.

The Council, an advisory body of lawyers appointed by the Supreme Court, expects to approve the proposal late this year in time for presentation to the January Session of the 1979 Legislature. The draft proposes creation of statute of limitations for medical malpractice as follows:

"(1) An action based on medical malpractice to recover damages for injury arising from any treatment or operation performed by, or from any omission by, a person who is licensed, certified, registered or authorized to practice as a health care provider under state law, regardless of the theory on which the action is based, shall be commenced:

(a) Within three years from the date of the act or omission constituting the malpractice, or

(b) Within one year from the date the injury was discovered or, in the exercise of reasonable diligence should have been discovered, except that an action cannot be commenced under this subsection more than six years from the date of the act or omission constituting the malpractice.

(2) The time limitations in sub (1) shall not apply:

(a) If a health care provider conceals from a patient his or her prior act or omission which has resulted in injury to the patient, in which case the action shall be commenced within one year from the date the patient discovers the concealment or, in the exercise of reasonable diligence, should have discovered the concealment, or

(b) When a foreign object which has no therapeutic or diagnostic purpose or effect has been left in a patient's body, in which case the action shall be commenced within one year after the patient is aware or, in the exercise of reasonable care, should have been aware of the presence of the object."

The State's current adult statute of limitations is three years from the alleged act or omission. Concealment is currently handled as "fraud" in a different section of the statutes, and "foreign objects" are handled by common law application rather than statutory definition. The State Supreme Court has on three separate occasions in recent years appealed to the Legislature to rewrite the medical malpractice laws to express the views being put forth by the Judicial Council. The Judicial Council does not propose to change the current statute of limitations for malpractice affecting minors which is three years or age ten, whichever is later.

The Judicial Council reports that about 94 percent of all liability claims are currently pressed prior to the end of the three-year statute and that the addition of the discovery rule could be expected to produce about a 4 percent increase in the number of claims filed prior to the new deadline. Insurance carriers have not expressed their views of the possible impact of such a change on premiums.

The SMS Physicians Alliance Commission's Medical Liability Committee will be giving further consideration to the proposed legislation. Comments are welcome. ■

Auxiliary launches new immunization awareness project

Recently there has been an alarming drop in immunization levels nationwide against the major vaccine-preventable childhood diseases.

Thus, the SMS Auxiliary developed a campaign to make both parents and children aware of the need for immunizations against measles, polio, diphtheria, whooping cough, tetanus, rubella, and mumps.

The Auxiliary enlisted the support of Acting Governor Martin Schreiber's wife, Elaine, in spearheading the campaign through a game of hopscotch. "Immunization" has been substituted for "Sky-blue" on the top of the game and each of the squares is labeled with a separate disease.

To kick off the project the Auxiliary held a press conference at the Executive Mansion July 21, during which Mrs Schreiber explained the campaign. The Schreiber's three-year-old son, Matthew, played hopscotch on a stenciled court on the front grounds of the Governor's home.

The Auxiliary will be stenciling this public awareness tool on playgrounds across Wisconsin.

As honorary chairperson of WINK —Wisconsin Immunization Now for Kids—Mrs Schreiber has been appearing at immunization clinics around the State stressing the importance of immunization against these infectious childhood diseases.

She points out that "28 percent of all children entering kindergarten are not immunized. Through fun and advertising we hope to make parents more aware of the need for immunization."

Representing the Auxiliary at the press conference were Mrs Charles R (Nell) Lyons, Oshkosh, president of the SMS Auxiliary; Mrs Kenneth M (Mary) Smigielski, Milwaukee, president-elect of the SMS Auxiliary; Mrs Sigurd E (Helen) Sivertson, Madison, Southwest Region director; Mrs Howard W (Betty) Mahaffey, Madison, Southwest Region reporter; Mrs Harold E (Sharon) Manhart, Madison, president of Dane County Medical Auxiliary; and Mrs James (Betty) Land, Madison, Community Health and Science chairperson for Dane County Medical Auxiliary. Mrs Bernard (Laverne) Bartel, executive secretary of the SMS Auxiliary, arranged the conference.

The SMS Auxiliary in 1978-79 is celebrating its 50th anniversary. To commemorate the date on which the Auxiliary was founded, all Auxiliary members have been invited to a tea at the Executive Mansion on Wednesday, September 13, the same date as the founding 50 years ago. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.34 as of June 30, 1978. ■

JUNE 1978 BLUE BOOK UPDATE

In the listing of County Medical Society presidents and secretaries, pages 89-91, the following changes have occurred:

FOND DU LAC: James E Schuster, 333 N Peters Ave, Fond du Lac 54935 is secretary.

OUTAGAMIE: William B Grubb Jr, 424 East Wisconsin Ave, Appleton 54911 is president; and William R Richards, 900 East Grant St, Appleton 54911 is secretary.

On page 90 the president of Monroe County Medical Society is Gustave A Landmann (not Gustave A Landrum).

In the listing of Presidents and Secretaries, Wisconsin Specialty Societies on page 95, the Wisconsin Chapter, American College of Emergency Physicians was inadvertently omitted.

President—C Randolph Turner (Oct 1978), 7335 Maple Terrace, Milwaukee 53213

Secretary—Timothy J Helz (Oct 1978), 32306 W Hwy 16, Hartland 53029. ■

House of Delegates Nominating Committee to meet Sept 24

The House of Delegates Nominating Committee will hold a meeting Sunday, September 24, 10:00 AM at the SMS headquarters in Madison.

County and specialty medical societies are urged to nominate members for the offices of president-elect and vice-speaker for 1979-80, speaker for 1979-81, and AMA delegates and alternates for calendar years 1980-1981.

Currently Darold A Treffert, MD, Winnebago, is president-elect; Albert J Motzel, Jr, MD, Waukesha, is speaker; Duane W Taebel, MD, La Crosse, is vice-speaker.

AMA delegates whose terms expire at the end of 1979 are MDs Gerald J Derus, Madison, and Henry F Twelmeyer, Wauwatosa.

AMA alternate delegates with similarly ending terms are MDs Warren H Williamson, Racine, and John R McKenzie, Jr, Oshkosh.

Nominations with curriculum vitae should be sent to the Nominating Committee in care of the SMS office in Madison as soon as possible. All candidates and their sponsors are encouraged to present themselves at the September meeting. ■

Members, Committee on Nominations of House of Delegates

The Committee on Nominations consists of four delegates from District 1, two from District 2, and one each from Districts 3, 4, 5, 6, 7 and 8, plus one delegate representing the specialty sections. The Committee must meet at least two months prior to the 1979 annual session to prepare the appropriate slate of candidates for office to be filled for the next year.

Chesley P Erwin MD, Milwaukee
John D Riesch MD, Menomonee Falls
David N Goldstein MD, Kenosha
Jerome J Veranth MD, Racine
District One

James N Moore MD, Madison
James J Tydrich MD, Richland Center
District Two

Vernon M Griffin MD, Mauston
District Three

Richard Ulmer MD, Wood
District Four

Kenneth M Viste Jr MD, Oshkosh
District Five

Gilbert H Stannard Jr MD, Manitowoc
District Six

John A May MD, Baldwin
District Seven

Joseph M Jauquet MD, Ashland
District Eight

Joel E Taxman MD, Milwaukee
Specialty Sections

A list of Delegates and Alternate Delegates to the House of Delegates of the State Medical Society of Wisconsin appeared in the March 1978 issue, page 42. ■

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

June 3, 1978—Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 1:40 pm on Saturday, June 3, 1978, at the State Medical Society.

Voting members present: Chairman Haskins; Vice-chairman Flaherty; Doctors Mullooly, Eisenberg, Boulanger, Bruhn, Foley, Nielsen, Steffen, Tuftee, Waterhouse, Crowley, Natoli, Kief, Lewis, Peters, Barrette, Jauquet, Larsen, Levin, Treffert, and Taebel.

Others present: Doctors Nordby, Williams, Scott, Lubitz, Kirkpatrick; Mmes Lyons and Smigielski; Messrs Thayer, Maroney, Johnson, Wood, Nelson, Jensen, LaBissoniere, Brozek, Mendelson, Reas; Ms Bartel, Riley, Upton; Miss Pyre.

2. Oath of Office

The oath of office was administered to Darold A Treffert, MD, as president-elect of the Society.

3. Approval of Minutes

Minutes of the April 12 and 15, 1978, meetings were approved as distributed.

4. Report of Executive Committee

Doctor Levin reported the following committee recommendations, noting that others would be presented on specific Council agenda items:

A. Resident Physicians Section

On motion of Doctors Levin-Larsen, carried, the Council concurred with the basic proposal of the RPS that their dues be increased by $10 to a total of $13 (plus county and AMA), but that the additional $10 be billed as Section rather than SMS member dues.

In addition, the Council encouraged the Wisconsin delegation to the AMA to assist in whatever ways possible the campaign of Steven Imbeau, MD, Madison, for election to the presidency of the AMA-RPS.

B. Opinion Poll on Unified Membership

On motion of Doctors Levin-Crowley, carried, the Council accepted the committee proposal to implement the recommendation of Councilor Kief with a simple opinion poll limited to the question of unified membership, defining what it means, and including all physicians in the state.

C. Surgical Second Opinion Program of HEW

HEW has announced that starting in mid-June it will launch a nationwide promotion program to encourage Medicare and Medicaid patients to use second opinions for all surgery. HEW has asked the PSROs to assume responsibility for developing and maintaining lists of surgeons who will act as second opinion consultants.

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On motion of Doctors Levin-Larsen, carried, the Council concurred in a position of no opposition to that method of handling the referrals.

Question was raised as to how physicians would be selected for the referral lists. Doctor Kief suggested that the PSROs could report back to the Council for information.

D. DHSS Employment of Physicians for Peer Review

On motion of Doctors Levin-Larsen, carried, the Council agreed that the Society oppose by legislative and other means a proposal of DHSS to conduct independent medical review of nursing homes through state-employed physicians rather than privately practicing physicians.

E. Expanded Membership of Commission on Health Planning

On motion of Doctor Levin, seconded and carried, the Council approved this Commission's proposal that chairmen of Physician HSA Task Forces and a representative of each specialty section/society be accorded voting membership on the Commission on Health Planning. This is comparable to the Governmental Affairs Commission which includes a member from each of the specialty sections who have voting rights when present but need not be counted for purposes of a quorum.

5. Physicians Alliance Commission

In the absence of Chairman Viste, Mr Jensen summarized the Commission's report, which included recommendations that certain of its members be appointed as the Society's representatives on the Wisconsin Health Care Liability Insurance Plan board of governors and the actuarial and underwriting subcommittee, for purposes of direct liaison with the Commission which has responsibility in the professsional liabilty arena.

Doctor Nordby, current SMS representative on the board of governors, asked if there was "cause" for recommending a replacement, indicating he felt continuity was important and that he enjoyed good relationships with members of the board.

On motion of Doctors Kief-Waterhouse, carried, this matter was tabled until the next Council meeting.

Mr Jensen gave a detailed slide presentation on the Title 19 interim contract, the accompanying letter from Secretary Percy, the access to medical records issue, terms of reimbursement, pros and cons, and optional strategies as regards the forthcoming "Super-Rule" and any new contract.

Doctors Levin-Foley moved approval of the following action recommended by the Executive Committee, which carried after discussion:

1. The Council reaffirms its authority to the Physicians Alliance Commission, staff and legal counsel to negotiate the best possible contract and to not recommend to the membership any course of action, believing that the decision to sign the interim contract rests with the individual physician.

2. The Council affirms that this position relates solely to the currently proposed interim contract and that the future objectives of the Society are:

   A. That if the performance of both the Department of Health and Social Services and EDS Federal does not significantly improve, and if the "Super-Rule" is not acceptable to physicians, the Society will then recommend to the membership that the [new] contract is likewise not acceptable;

   B. That the Council of the Society calls upon all Title 19 recipients and appropriate organizations to join the Society in a concentrated effort to effect changes in the "Super-Rule" to improve and protect recipient rights in the Medical Assistance program, with special emphasis on the access to patient records and a preservation of the physician-patient relationship;

   C. That the Society immediately inform the membership of these objectives, as well as the Governor and Secretary of the Wisconsin Department of Health and Social Services; and

   D. That the Physicians Alliance Commission and staff begin immediately to work for repeal of current statutory language requiring the Title 19 contract and to substantiate specific language authorizing the use of individual claim form agreements such as now in effect and permitted by federal law.

6. Committee on Evaluation of Delivery and Cost of Medical Care

Doctor Waterhouse summarized the informational report from this committee as distributed to the Council, relating to planned joint activities with the Wisconsin Hospital Association in support of the national Voluntary Effort on cost containment.

7. Interim Steering Committee on Peer Review

Doctor Waterhouse presented a report incorporating recommendations of the committee developed in final form the preceding day in a meeting with representatives of interested nonmedical organizations.

As regards the initial policy-making board composition, Doctor Levin reported the recommendation of the Executive Committee that the number of physicians representing the SMS be increased from 10 to 12 and include in addition Secretary Thayer. The proposed board would have another 12 persons representing the PSROs, Wisconsin Hospital Association, Blue Plans, commercial insurance, business and labor.

Doctor Levin presented a slate of nominees for the SMS representatives on the initial board.

Considerable discussion ensued relative to the report containing goals and objectives for a statewide foundation for peer review of medical care, developed by the steering committee pursuant to action of the House of Delegates. Doctor Lewis and others requested more information and time for study and specifically to allow opportunity for consideration by WisPRO.

Only one formal action was taken: on motion of Doctors Eisenberg-Taebel, carried, the Council authorized a one-time grant to the proposed new foundation of no more than $5,000 to be used for first-year start-up funding.

8. Finance Committee

A. Doctor Foley reported that as the Pension Plan Managing Committee, the audit report and investment portfolio were received, and action was taken to notify WPSIC that its employees will be separated from participation in the current joint plan effective December 31, 1978.

B. The committee reviewed and received audit reports on the Society, Realty Corporation, and Foundation. The general trend is favorable in dues and investment income; budget is overexpended through April by $13,000 in total, with the major "over-budget" items being telephone (in-WATS line) and payroll expenses related primarily to termination of office services use by WPSIC.

C. The Society, through WHCRI, is involved in a joint study with DHSS of the medical necessity for surgery in Wisconsin. The committee recommended reimbursement to WHCRI of $400 in committee expenses and inquired of the Council whether it wished to continue funding the study. Doctor Levin, a member of the committee, believed it was worth while and should be continued.

On motion of Doctors Foley-Crowley, carried, the Council approved continued funding of this study committee.

D. The Society's general insurance coverage has been placed with Employers Insurance at a premium savings. As part of the package, the deductible on auto collision coverage was increased to $250, and the committee recommended that employee responsibility continue at $100.

This was approved on motion of Doctors Foley-Crowley, carried.

E. The committee discussed that provision of the bylaws which precludes councilors being reimbursed for expenses in attending the annual session of the Society, and whether this should apply to all voting members of the Council which would include the Immediate Past President, Speaker and Vice Speaker, but not the President and President-elect for whom an expense reimbursement fund is budgeted.

On motion of Doctor Kief, seconded and carried, the Council agreed that the three specified officers be included with councilors under this bylaw.

F. On motion of Doctors Foley-Kief, carried, the Council approved dues for the new nonresident membership category at 30% of regular dues.

G. On motion of Doctors Foley-Kief, carried, the Council agreed there should be a break even budget for the Practice Management Seminars planned by the Committee on Economic Medicine.

9. Economic Medicine Committee

Doctor Flaherty reported the following for Council information or action:

A. On motion of Doctor Flaherty, seconded and carried, the Council reaffirmed its April action on formation of a "for profit" corporation.

B. An agreement has been signed with IC System, Inc, and a mailing announcing the collection service to members will be sent shortly.

C. The committee approved the tentative program and costs for Practice Management Seminars in September in Eau Claire, Green Bay, and Madison.

D. The committee received a report from Mr Frank Thatcher on the Wisconsin Health Care Liability Insurance Plan, and on motion of Doctors Flaherty-Crowley, carried, the Council agreed that the SMS should be present at and have an opportunity for representation in the consideration of any loss control mechanism formed by WHCLIP.

E. The committee has endorsed the substitution of the WPS Medicare-Companion policy for SMS member group subscribers becoming eligible on and after July 1, 1978, with the provision that present group holders of Medicare-Plus policies be presented with a comparison of the two policies and given the option of retaining Medicare-Plus or transferring to Medicare-Companion coverage.

10. Miscellaneous

Councilors were informed of and invited to join the June 16 meeting of the Physicians Alliance Commission with Acting Governor Schreiber.

On motion of Doctors Nielsen-Larsen, carried, the previously scheduled October 14 and November 11 Council meeting dates were combined in a new date of October 28 beginning at 9 am, with committee meetings held on Friday, October 27.

Doctor Nielsen submitted his resignation from the Committee on Occupational Health, and on motion of Doctors Larsen-Kief, carried, Donald Rowe, MD, was appointed.

Doctor Peters noted that resolutions to be considered by the AMA House of Delegates had been published in AMNews, and expressed the view that the Wisconsin delegation should have been present to discuss them with the Council. [The delegation had scheduled a meeting for handbook review the following weekend.]

11. Adjournment

The balance of the agenda was laid over and the meeting adjourned at 5:25 pm.

EARL R THAYER
Secretary

Approved August 5, 1978
PAUL S HASKINS, MD
Chairman

■

Brief Summary of Prescribing Information
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For complete information, consult Official Package Circular. (12) TEGOPEN 9/11/75
Indications: Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)
Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.
Important Note: When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.
Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.
Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.
Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.
Contraindications: A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.
Warning: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.
There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.
Safety for use in pregnancy has not been established.
Precautions: The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.
As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.
Adverse Reactions: Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.
Usual Dosage: Adults: 250 mg. q.6h.
Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.
N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.
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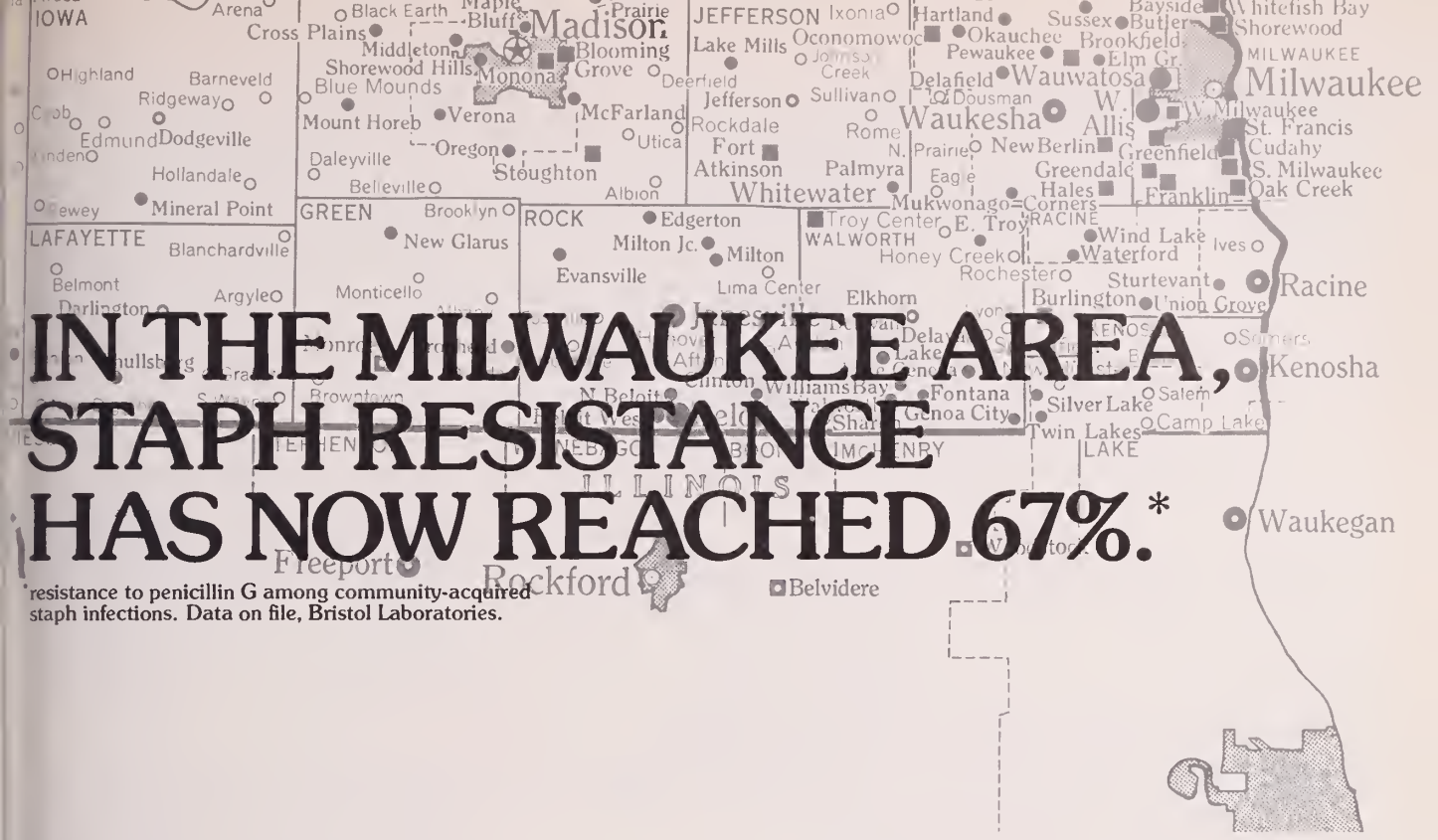

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*resistance to penicillin G among community-acquired staph infections. Data on file, Bristol Laboratories.

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†NOTE: The choice of Tegopen should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates that the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semisynthetic penicillin. The clinical significance of in *vitro* data is unknown.

- 10 times more active against strep than staph.
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‡Maximum absorption occurs when Tegopen is taken on an empty stomach, preferably 1-2 hrs. before meals.

Please see brief summary for prescribing information.

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of July 14, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

GRANT

Khayai, Abed L, 229 N Wisconsin Ave, Muscoda 53573 (1938, Regular, Cardiovascular Diseases)

MANITOWOC

Bell, Roger A, 300 E Reed Ave, PO Box 277, Manitowoc 54220 (1940, Regular, Otorhinolaryngology, Certified)

Curtiss, Carl M, 601 Reed Ave, PO Box 279, Manitowoc 54220 (1946, Regular, Internal Medicine/Cardiovascular Diseases, Certified-IM)

Finnegan, Thomas L, 600 York St, Manitowoc 54220 (1944, Regular, Orthopedic Surgery)

MILWAUKEE

Chambers, Laroyce F, 2711 W Wells St, Milwaukee 53208 (1944, Regular, Obstetrics and Gynecology)

Dorros, Gerald, 2040 W Wisconsin Ave, Milwaukee 53233 (1942, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)

Otto, Samuel J, 8975 W Howard Ave, Greenfield 53228 (1945, Resident, Urological Surgery)

Pakalinis, Vytautas A, 8700 W Wisconsin Ave, Milwaukee 53226 (1949, Resident, Ophthalmology)

Wiener, Marvin, 3533 E Ramsey Ave, Cudahy 53110 (1947, Regular, Family Physician, Certified)

SHAWANO

Pearlman, Jeffrey J, PO Box 232, Keshena 54135 (1949, Regular, General Practice)

VERNON

Menn, Jeffrey F, 318 W Decker, Viroqua 54665 (1948, Regular, Pediatrics)

WAUKESHA

Blick, Michael J, 19500 Warwick Ave, Brookfield 53005 (1944, Regular, Internal Medicine, Certified)

Ruggaber, Garren C, W180N7950 Town Hall Rd, Menomonee Falls 53051 (1948, Regular, Radiology)

WOOD

Kayali, Bashar F, 1000 N Oak Ave, Marshfield 54449 (1951, Resident, Pediatrics)

Septer, Steven H, 120 W Jefferson, Marshfield 54449 (1950, Resident, Unspecified)

Tarabishi, Farida N, 1000 N Oak Ave, Marshfield 54449 (1944, Regular, Child Psychiatry)

Wasserman, Anatolio, 1000 N Oak Ave, Marshfield 54449 (1942, Regular, Orthopedic Surgery)

CHANGE OF ADDRESS

(Does not include those within a city)

County Medical Society

ASHLAND-BAYFIELD-IRON

Trudeau, David L, Washburn, to 1246 Dry Creek, Derby, KS 67037

BROWN

McCullough, Lynne S, DePere, to 3919 Bancroft St, Toledo 53606

DANE

Finch, David R, Madison, to 1831 North Douglas Ave, Appleton 54911

Graber, Benjamin, Madison, to 602 S 45th St, Omaha NB 68154

Greer, James A, Madison, to 261 Rutland St, Wichita, KS 67206

Hussey, John L, Cross Plains, to 911 Hessmer Ave, Metairie, LA 70002

Lari, Steven J, Madison, 410 Groveland Ave, Minneapolis, MN 55403

Meschievitz, Carlton, New Delhi, India, to 1224 MacArthur Ave, Ashland 54802

Olson, Janet E, Madison, to 709 Hanley Dr, Sun Prairie 53590

Poeschel, Bernard B, Middleton, to Rte #1, Box 126A, Eleva 54738

Schmitz, Peter W, Omaha, NB, to 768 Manchester Rd, Neenah 54956

Totel, Gregory L, McFarland, to 261 East Division St, Fond du Lac 54935

EAU CLAIRE-DUNN-PEPIN

Peterson, Dale H, Eau Claire, to 1501 Southeast 19th St, Edmond, OK 73034

MANITOWOC

Kangayappan, S, Cleveland, OH, to 601 N 30th St, Omaha, NB 68131

MILWAUKEE

Harvey, William D, Wauwatosa, to 300 Branded Blvd, Kokomo, IN 46901

ONEIDA-VILAS

Pederson, John F, Minocqua, to 4042 Brookside Lane, LaCrosse 54601

WINNEBAGO

Regan, David M, Neenah, to 258 Selby Ranch Rd, Sacramento, CA 95825

DEATHS

Schlenker, Leo T, Kenosha County, June 20, 1978

Edwards, Paul K, Ashland-Bayfield-Iron County, June 23, 1978

Urban, Frank, Brown County, July 1, 1978 ■

OBITUARIES

◈County, State, AMA Members

◈ **Karl E Kassowitz, MD,** 92, former Milwaukee physician died Apr 6, 1978 in Boulder, Colo. Born Jan 8, 1886 in Vienna, Austria, Doctor Kassowitz graduated from the University of Vienna School of Medicine in 1910. He had been an associate clinical professor of pediatrics at Marquette University School of Medicine for many years. In 1975 he was granted a Life Membership in the State Medical Society of Wisconsin. Surviving are his widow, Annie; and three daughters, Verena Fjermestad, Nigeria; Mrs John Peper, Singapore; and Marlis Martin of Laguana Beach, Calif.

◈ **Joshua H Armstrong, MD,** 81, New Richmond, died May 20, 1978 in New Richmond. Born Sept 28, 1896 in Ireland, Doctor Armstrong graduated from Marquette University School of Medicine in 1925. He had practiced medicine in New Richmond since 1925. Surviving are his widow, Florence; one son, Thomas, Santa Barbara, Calif, and one daughter, Mrs Robert (Rita) Kasper of Minneapolis, Minn.

◈ **George Joseph Schroth, MD,** 64, Wausau, died May 28, 1978 in Wausau. Born Dec 12, 1913 in St Paul, Minn, Doctor Schroth graduated from St Louis University Medical School in 1939. He served in the United States Army from 1941-1945. Doctor Schroth had practiced in Wausau for 30 years. Surviving are his widow; and a daughter, Sandra, Steamboat Springs, Colo; and a son, Walter, Spring Park, Minn.

Eleanor C Struck, MD, 82, West Bend, died June 11, 1978 in Port Washington. Born Nov 1, 1895 in Door County, she graduated from Marquette University School of Medicine in 1937. Doctor Struck was the former assistant medical director at the Milwaukee County Hospital for mental diseases and also served as medical director at Good Samaritan Hospital, West Bend. Surviving are two sons, Norman, Newburg, and Howard, Milwaukee.

Joseph Frank Mueller, MD, 77, Plymouth, died July 2, 1978 in Plymouth. Born Sept 4, 1900 in Sheboygan, Doctor Mueller graduated from Marquette University School of Medicine in 1924. He practiced in the Plymouth area for 50 years. Surviving are his widow, Corrinne; two daughters, Mrs Floyd (Jacqueline) Bensen, Pasadena, Calif, and Mrs James (Corrinne) Jeffers of Green Bay.

Eleanor V Kuehn, MD, 56, Bonduel, died July 13, 1978 in Bonduel. Born Feb 26, 1922 in Milwaukee, Doctor Kuehn graduated from Marquette University School of Medicine in 1947. She was a consultant for Unified Health Services in Shawano, Waupaca, and Oconto counties and was a psychiatric advisor for the North Woods Mental Health Center at Rhinelander, and for the Family Health Services, Green Bay. Surviving are her husband, Carl: three daughters, Nora, Minneapolis; Lynne and Amy at home; and one son, Robert, Suamico. ■

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The Marshfield Clinic

. . . recently announced the addition of four new physicians to its medical staff. The four, MDs Roberto Cantillo, Michael Seelen, and Preecha Supanwanid, and James Asher, DO, brings the clinic's medical staff to 160. Doctor Cantillo graduated from the University of Costa Rica Medical School and served his residency in internal medicine at Henry Ford Hospital, Detroit. He also completed an oncology fellowship at Wayne State University. Doctor Seelen received his medical degree from Georgetown University School of Medicine and completed his residency in urology at Columbia University, New York. Doctor Supanwanid graduated from the Mahidol University Medical School, Bangkok, Thailand, and came to the United States in 1972 where he accepted a surgical research fellowship at the University of Colorado Medical Center, Denver. Doctor Supanwanid also completed a surgical residency at the University of Rochester, Rochester, New York. Doctor Asher graduated from the College of Osteopathic Medicine and Surgery, Des Moines. He served his residency in family practice at the University of Nebraska Medical Center, Omaha.

American Academy of Pediatrics

. . . will hold its Annual Meeting October 21-26 at the Palmer House Hotel in Chicago. A special scientific session on "controversies in pediatrics" will be among the presentations. The six-day meeting will feature reports on a wide variety of topics, including high risk pregnancy, drug abuse, parenting, growth disorders, and newborn surgical emergencies. The "controversies" session will focus on subjects such as sudden infant death, treatment of childhood diabetes, phenobarbital therapy, and the use of steriods. A series of seminars will concentrate on such subjects as hyperactivity, adolescent medicine, learning disabilities, athletic injuries, immunodeficiency disease, and nutrition. Workshops will include discussions of legislative issues and health maintenance programs. Richard W Heim, Medicaid Director, DHEW, will discuss new directions for Medicaid and federal financing of health services at the Council on Pediatric Practice open forum. Further information may be obtained by calling the AAP in Evanston, Ill: 312/869-4255.

St Mary's Medical Center

. . . Racine, recently announced the following new officers of its medical staff. They are MDs Victoriano A Baylon,* chief-of-staff; Leo R Grinney,* vice chief-of-staff; Robert F Scheller,* secretary; and William C Harris,* serves as immediate past chief-of-staff. Department chiefs elected include MDs Marvin G Parker,* Medicine; Donald R Burke,* Surgery; Leo R Grinney,* Gynecology; John W Foreman* Pediatrics; and Raymond E Skupniewicz,* Family Practice. Appointed to the executive committee of the hospital are MDs Robert F Siegert,* Emergency Committee; Huron L Ericson,* Utilization Review; and Richard Minton,* Medical Audit. All the physicians are from Racine.

Wisconsin Nurses Association

. . . will hold its annual convention October 3-6 at the Olympia Princess Resort (at Scotsland) in Oconomowoc. Details of the program appear in the YELLOW PAGES section of this issue.

American Rheumatism Association

. . . headquartered in Atlanta, Ga, recently announced the new president-elect as Daniel J McCarty, MD,* Milwaukee. Doctor McCarty, professor and chairman of the department of medicine of the Medical College of Wisconsin, Milwaukee, and director of the department of medicine of Milwaukee County General Hospital will take office in 1979. Doctor McCarty of Hartland is a board member of the Arthritis Foundation of Wisconsin and has been involved with the work of the Foundation since 1960. He has just completed three years as chairman of the Foundation's research committee. He also was editor-in-chief of *Arthritis and Rheumatism,* the official journal of the ARA from 1965-1970 and is presently editor-in-chief of the 9th edition of *Arthritis and Allied Conditions.*

A series of articles on arthritis is appearing in the scientific section of this issue of the *Wisconsin Medical Journal* in which Doctor McCarty is an author. ■

PHYSICIAN BRIEFS

Cesar Chavez, MD

. . . Shullsburg, recently became associated with the medical staff of Lafayette County Community Health, Inc and is practicing full-time at the Shullsburg Clinic. Doctor Chavez, a native of Calexico, California, is a graduate of the University of Washington School of Medicine, Seattle, and completed his family practice residency program at Kaiser Foundation Hospital, Fontana, Calif.

Joel L Furda, MD

. . . Rhinelander, recently became associated with the Warner S Bump Medical Group. A 1973 graduate from the University of Iowa Medical School, he served his internship and residency training at Hennepin County Hospital in Minneapolis.

R Scott Liebl, MD

. . . Woodruff, recently joined the Lakeland Medical Associates in the Department of Surgery. A native of Luxemburg, Doctor Liebl graduated from the Medical College of Wisconsin, and served his internship and residency at West Virginia University Hospital, Morgantown.

Rolando Buan, MD*

. . . Tomah, recently became associated with the Tomah Memorial Hospital as a staff surgeon. Doctor Buan, who was affiliated with the Sparta Clinic from 1971-1976, is returning from a fellowship in general surgery at St Joseph's Hospital, Milwaukee.

Howard H Kay, MD

. . . Manitowoc, has joined the medical staff of the Manitowoc Clinic. He graduated from Harvard University Medical School and served his internship and residency in Yale-New Haven Hospital, New Haven, Conn. He is specializing in pediatrics.

Kenneth Yuska, MD

. . . Marinette, recently opened his medical practice in orthopedic surgery. He graduated from New York Medical College in 1971 and completed his residency at Hershey Medical Center, Penn State University. Prior to moving to Marinette, Doctor Yuska had practiced at Darnall Army Hospital, Fort Hood, Texas. He is affiliated with Marinette General Hospital.

□ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. □ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Steven Cook, MD

. . . Eau Claire, recently opened the Cook Family Health Center and also became a member of the medical staff of St Joseph's Hospital. A family physician, Doctor Cook graduated from Northwestern University Medical School in Chicago and served his residency at Long Beach Memorial Hospital in California.

Cesar V Sison, MD*

. . . Kewaskum, was reelected president of the medical staff of St Joseph's Community Hospital, West Bend. Doctor Sison joined the medical staff in 1971 and also serves as a member of the board of directors of the hospital. MDs Richard E Zellmer,* Milwaukee, and Robert T Bodensteiner,* West Bend, were elected vice-president and secretary-treasurer, respectively.

Edward J Lennon, MD*

. . . recently has become the dean and academic vice-president of the Medical College of Wisconsin succeeding Gerald Kerrigan, MD, who had been dean from 1966-1978. Doctor Lennon has been serving as acting dean since January. Doctor Lennon joined the Medical College of Wisconsin in 1958 as an instructor in medicine, was promoted to assistant professor in 1961, to associate professor in 1966, and to professor in 1968. From 1960 to 1970 he was chief of the renal section in the Department of Medicine. He was appointed associate dean for clinical affairs in 1968, associate dean for academic affairs in 1971 and associate dean in 1972. He graduated from Northwestern University School of Medicine in 1952. Doctor Lennon also was awarded a one-year United States public health service research fellowship in renal disease at Massachusetts Memorial Hospital in 1960. A specialist in renal or kidney diseases, he was the first project director of the Clinical Research Center at Milwaukee County Medical Complex.

Richard L Shaffer, MD

. . . Green Bay, recently became associated with MDs Donald Sipes* and Edward Vogel* at Bay West Gynecology and Obstetrics, Ltd. A native of Ohio, Doctor Shaffer graduated from Ohio State University Medical School and completed his internship and residency at University Hospitals, Madison. He has been an instructor at the University of Nebraska Medical Center and Creighton University School of Medicine in Omaha, and has just completed two years in the United States Air Force at Offutt Air Force Base, Omaha, NB.

Jacob Gerend, MD*

. . . Sheboygan, has joined the medical staff at St Nicholas Hospital in the Department of Radiology. He previously was staff radiologist at St Agnes Hospital, Fond du Lac; Ripon Memorial and Berlin Memorial hospitals.

Larry S Goodlund, MD
William M Nissen, MD
James R Stjernholm, MD

. . . recently have joined the medical staff of the Gundersen Clinic, Ltd, LaCrosse. Doctor Goodlund, specializing in child/adolescent psychiatry, graduated from the University of Minnesota Medical School and his residency training was taken at the Mayo Graduate School of Medicine, Rochester. Doctor Nissen graduated from the University of Iowa Medical School and served his internship at LaCrosse Lutheran Hospital and his psychiatry residency at Cherokee Mental Health Institute. Doctor Stjernholm, a specialist in internal medicine, graduated from the University of Colorado Medical School in Denver. His internship and residency training were taken at the Gundersen Clinic Ltd/Lutheran Hospitals.

David G Dibbell, MD*

. . . Stoughton, recently was awarded the James Barrett Brown prize in plastic surgery for his advancement of knowledge in the field of plastic and reconstructive surgery. Doctor Dibbell is chairman of the Department of Plastic Surgery at University Hospitals in Madison.

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Daniel Johnson, MD

. . . Rhinelander, recently became associated with the Warner S Bump Medical Group. Doctor Johnson graduated from the University of Minnesota Medical School and served his internship and residency at the St Paul-Ramsey Hospital and the Minneapolis Veterans Administration Hospital.

Richard O'Connor, MD*

. . . Wausau, has been appointed clinical professor of pediatrics at the University of Wisconsin Center for Health Sciences, Madison. Doctor O'Connor has been clinical instructor in pediatrics at the medical school since 1972. He currently is on the medical staff of the Wausau Medical Center and Wausau Hospitals, Inc. Doctor O'Connor graduated from the University of Wisconsin Medical School, Madison, and served his residency training at Yale-New Haven Hospital in New Haven, Conn.

Ralph C Frank, MD*

. . . Eau Claire, recently was elected president of St Joseph's Hospital medical staff. MDs Warren K Wright* and Reynaldo C Maniquiz,* both of Chippewa Falls, were elected vice-president and secretary, respectively. The new officers were elected for a one-year term.

Maxine Bennett, MD*

. . . former chairman of the University of Wisconsin Medical School Department of Otolaryngology, retired in June. Doctor Bennett, Madison, has been on the medical school faculty full-time for 25 years. She will continue working as a part-time consultant with the Veterans Administration Hospital in Madison. Doctor Bennett was the first woman member of the American Laryngological, Rhinological and Otological Society. She is presently on the Food and Drug Administration over-the-counter drug review panel.

Daniel Kincaid, MD*

. . . Eau Claire, recently was elected chief-of-staff at Sacred Heart Hospital succeeding Joseph Tobin, MD.* Doctor Kincaid has been a member of the medical staff since 1973 and has served as chairman of the Department of Medicine at Sacred Heart Hospital. Stanley Norman, MD,* Eau Claire, was elected vice-chief-of-staff and David Katz, MD,* Altoona, was named secretary-treasurer.

Warren A Brauer, MD
Patrick R Marsho, MD

. . . Sheboygan, recently became associated with Bernard S Marsho, MD* in the specialty of family practice. MDs Patrick Marsho and Warren Brauer recently completed their family practice residency at the University of Illinois, Rockford School of Medicine. Doctor Brauer is a 1975 graduate from the University of Missouri School of Medicine, Columbia, and Doctor Marsho is a 1975 graduate of the Medical College of Wisconsin.

M Thomas Chemotti, MD

. . . Cedarburg, recently opened his office in the practice of ophthalmology at the Grafton Medical Center. A 1974 graduate of the Medical College of Wisconsin, Doctor Chemotti served his residency at the University of Kentucky Medical Center in Lexington.

Maruthi Kantamneni, MD

. . . recently opened his medical office in Doctors Park, Platteville. A native of India, Doctor Kantamneni graduated from Gunter Medical College and completed residency in internal medicine in the British system of medical schools. He has taught clinical subjects in internal medicine at Gunter Medical College and came to the United States in 1974 where he completed his residency in internal medicine and a fellowship in cardiology at Jamaica Hospital in New York.

J Jay Goodman, MD*
Mark C Kiselow, MD*
Marvin Wagner, MD*

. . . have recently become associated with the medical staff of the Ozaukee Medical Center. Doctor Goodman is a clinical instructor of surgery at the Medical College of Wisconsin, and consulting surgeon at Milwaukee County General Hospital. Doctor Kiselow is an assistant clinical professor of surgery at the Medical College of Wisconsin, and a consultant in surgery at the Veterans Administration Hospital, Wood. Doctor Wagner is a clinical professor in the department of surgery at the Medical College of Wisconsin and also an adjunct clinical professor of surgery in anatomy at the Medical College of Wisconsin.

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Eric Weber, MD

. . . Hartford, recently became associated with the medical staff of Parkview Medical Associates, Ltd. Doctor Weber graduated from the Medical College of Wisconsin. He recently completed his residency in internal medicine at Southern Illinois University School of Medicine and Affiliated Hospitals, Springfield, Ill.

John D Wilkinson, MD*

. . . Oconomowoc physician for 50 years, recently was honored for his golden jubilee as a physician. Doctor Wilkinson received his medical degree from Marquette University School of Medicine in 1928. He has delivered between 5,000 and 6,000 babies and still devotes full-time to his practice. He is medical director for Lutheran Homes of Oconomowoc and at one time served two terms as chief-of-staff of Memorial Hospital at Oconomowoc.

Chesley P Erwin, MD*

. . . Wauwatosa, recently was installed as vice-president of the Milwaukee Academy of Medicine. John P Mullooly, MD,* Milwaukee, was installed as librarian and MDs Richard Bourne* and Thomas Russell,* Milwaukee, were installed as president-elect and secretary, respectively.

Thomas J Lang, MD

. . . Beloit, recently was named president of the medical staff at Beloit Memorial Hospital. Doctor Lang has resided in Beloit since 1960. Other MDs elected as officers are Dionisio B Pili,* president-elect and Timothy A Manning,* secretary of Beloit.

Kevin Parent, MD*

. . . Marshfield, recently spoke on "Crohn's Disease" at the State Medical Society's Annual Meeting in Milwaukee. Doctor Parent, a gastroenterologist at the Marshfield Clinic, presented his paper as the Elvehjem Memorial Lecture.

Edward G Schott, MD*

. . . president of the Sheboygan Clinic, recently announced that the pediatric wing of the Clinic was named the "Lloyd M Simonson Wing" in honor of Lloyd M Simonson, MD,* who retired in 1974. Doctor Simonson graduated from the University of Wisconsin Medical School, Madison, in 1933 and joined the Sheboygan Clinic in 1937. He served as chairman of the State Medical Society's Division on School Health and also on the board of directors of the Deland Foundation in Sheboygan. ■

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1978

7	WisPRO Lead Review Coordinator Meeting
10	Dane County Medical Society HMP Committee
10	Task Force on Health Screening and Immunization
11	Dane County Medical Society Board of Trustees
11	Uniform Claim Form
12	SMS Commission on Mediation and Professional Ethics
12	SMS Physicians Alliance Commission with Auxiliary Committees
19	WisPRO Executive Committee and Board of Control
20	SMS Commission on Public Information
21	SMS Physicians Alliance Commission/Candidate Interview Session
22	SMS Physicians Alliance Commission/Candidate Interview Session
25	SMS Committee on Aging and Extended Care Facilities
26	Ad Hoc Committee for an Independent Department of Health
28	SMS Commission on Continuing Medical Education

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

CONTINUING MEDICAL EDUCATION
MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 WISCONSIN

Sept 8: *Cardiac Potpourri,* presented by Adolf Gundersen Medical Foundation, LaCrosse Lutheran Hospital Heritage Club, and Wisconsin Heart Association. Midway Motor Lodge, 1835 Rose St, LaCrosse 54601. Further details appear elsewhere in this section.

Sept 14-16: *Wisconsin Society of Internal Medicine,* at Browns Lake Resort, Burlington.

Sept 15-16: American College of Physicians, Fox Hill Country Club, Mishicot, WI. Info: Charles L Junkerman, FACP, 831 N 66th St, Wauwatosa, WI 53213.

Sept 15-16: *Wisconsin Surgical Society,* Holiday Inn, Wausau, Wis 54401

Sept 15-16: *Wisconsin Neurosurgical Society,* Gundersen Clinic, LaCrosse, Wis 54601

Sept 22: Wisconsin Society of Plastic Surgery, Brynwood Country Club, Milwaukee.

Sept 22: *Pregnancy: Nutrition, malnutrition, metabolic considerations.* First annual nutrition conference, at Wisconsin Club, Milwaukee. Contact: Dept of Maternal-Fetal Medicine, Mt Sinai Medical Center, Milwaukee, tel 414/289-8323.

Sept 23-24: Wisconsin Allergy Society, Olympia Resort, Oconomowoc.

Sept 23-24: *Wisconsin Society of Anesthesiologists,* Playboy Club, Lake Geneva, Wis 53147

Sept 30: *Fall Cancer Conference,* Clinical Sciences Center, 600 North Highland Ave, Madison, WI. Info: Ms Millicent Baltus, American Cancer Society, Wisconsin Division. Tel: 608/249-0487.

Oct 2-3: *Selected Problems in Pediatric Neurology,* Dept of Neurology, The Medical College of Wisconsin, Milwaukee Children's Hospital, Milwaukee. Info: Jennie M Evenson, tel: 414/931-4074.

Oct 3-6: Wisconsin Nurses Association Annual Convention, Olympia Princess Resort (at Scotsland), Oconomowoc. See details elsewhere in this section.

Oct 12: Regional Cancer Conference, Pioneer Inn, Oshkosh.

Oct 13-14: Wisconsin Neurological Society meeting, Midway Motor Lodge, North Mayfair, Milwaukee.

Oct 14: *Wisconsin Radiological Society,* The Concourse, Madison, Wis 53701

Oct 16: *Milwaukee Academy of Medicine,* University Club of Milwaukee, Milwaukee, Wis 53202

Oct 27-28: *Wisconsin Chapter, American College of Emergency Physicians,* Red Carpet Inn, Milwaukee, Wis 53202

Nov 3: *Pediatric Emergencies,* Fall Pediatric Day, Wisconsin Chapter, *American Academy of Pediatrics,* Wisconsin Center, Madison, Wis 53706

Nov 18: *Wisconsin Dermatological Society,* Milwaukee County General Hospital, Milwaukee, Wis 53202

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161 West Wisconsin Ave, Room 6012, Milwaukee, Wis 53203—414/272-3670
302 East Washington Ave, Madison, Wis 53703—608/251-1462

ANNUAL CONVENTION/Olympia Resort Hotel/Oconomowoc
Tuesday-Friday, October 3-6, 1978

Theme: *Challenge to Change: Transition to Tomorrow*

Opening ceremonies on Tuesday evening, October 3, will be highlighted by the keynote speaker, Anne Zimmerman, executive director of the Illinois Nurses Association and immediate past president of the American Nurses Association.

Wednesday, October 4, programs will include:
—A legislative forum, with tentative speakers: *Betty Ford,* wife of the former President of the United States, and gubernatorial candidates from Wisconsin.
—"Entry Into Practice," speaker: *Irene Ramey,* dean of School of Nursing, University of Minnesota.
—"Developing Influence and Power to Improve Patient Care," speaker: *Luther Christman,* dean of School of Nursing, Rush Medical Center, Chicago.
—"Competency in Nursing Practice."

Thursday, October 5, programs will include:
—"Adolescents and Contraception," speaker: *Phyllis Cooksey,* director of human resources, Planned Parenthood, Minnesota.
—"Pain and the Cancer Patient."
—"Geriatric Standards for Nursing Practice," speaker: *Sister Erika Bunke.*
—"Patient Education in Mental Health."

A banquet is planned for Thursday evening, October 5, at which time the March of Dimes "Nurse of the Year" will be announced. In addition, several prominent Wisconsin Nurses Association members will be presented with a Service Award, an honor bestowed for outstanding achievement and service to the Association, community, and nursing.

Friday, October 6, four simultaneous general sessions will be held:
—"Woman Power and Health Care," speaker: *Marlene Grissom,* co-author of the book, "Womanpower and Health Care," and director, School of Nursing, Central Methodist College, Fayette, Mo.
—"Self Care: Don't Leave Home Without It," speaker: *John Pilch,* psychologist, Medical College of Wisconsin, Milwaukee.
—"Nursing Research."
—"The Nurse Practice Act."

All registered nurses and nursing students are invited to attend.

1978 NEIGHBORING

Sept 7-11: *Medical Knowledge Self-Assessment Program Course,* Towsley Center, Ann Arbor, Mich. Info: Registrar, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Sept 11-13: *New Horizons in Rheumatic Diseases* at Rochester, MN. Accepted for 18¾ hours of Category I credit of the AMA-PRA. Info: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

Sept 26-30: *Medical Knowledge Self-Assessment Program Course,* Mayo Civic Auditorium, Rochester, Minn. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

CARDIAC POTPOURRI

Friday, Sept 8, 1978

Midway Motor Lodge
1835 Rose Street
LaCrosse, Wis

Presented by Adolf Gundersen Medical Foundation, LaCrosse Lutheran Hospital Heritage Club, and Wisconsin Heart Association

Program:

am
- 7:30 Registration
- 7:55 Welcome
- 8:00 "Physical Activity and Coronary Artery Disease-Epidemiologic Data," *Ralph F Paffenberger, MD*
- 9:00 "Long Term Followup Aorto-Coronary Bypass Patients," *Robert J Hall, MD*
- 10:00 Coffee Break
- 10:30 "Impact-Surgically Corrected Congenital Heart Lesions on Adult Practice —Warnings, Special Problems and Long Term Outlook," *S Gilbert Blount, MD*
- 11:30 Discussion

pm
- 12:15 Luncheon
- 1:30 "Difficult Arrhythmias-Diagnosis and Management," *William P Nelson, MD*
- 2:30 "New Concepts-Old Drugs. Digitalis and Pronestyl," *Frank I Marcus, MD*
- 3:30 Discussion
- 4:00 Adjourn

Registration deadline: Sept 1.

Program fee $20. Approved 6 hours of CME Category I credit by the AMA-PRA. Info: Medical Education Office, Gundersen Clinic, Ltd, 1836 South Ave, LaCrosse, Wis 54601.

Oct 10-14: *Medical Knowledge Self-Assessment Program Course,* Ambassador West Hotel, Chicago, Ill. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa

Oct 21-25: Annual Convention, Indiana State Medical Association, at Marriott Inn, Clarksville, Ind 47130

1978 OTHERS

Sept 18-21: *Pulmonary Medicine—An Update for the Clinician.* American College of Chest Physicians, The Mark Resort, Vail, Colo.

Sept 25-28: Annual Scientific Assembly, American Academy of Family Physicians, San Francisco.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

Nov 14-17: Thirty-second World Medical Assembly, Manila, The Philippines. Info: World Medical Association Inc, 13 Chemin du Levant, 01210 Ferney-Voltaire, France. *Without delay.*

1978 AMA

Dec 2-6: House of Delegates Interim Meeting. Chicago.

Dec 7-10: Winter Scientific Meeting. Las Vegas.

1979 WISCONSIN

Jan 4-10: Medical College of Wisconsin annual postgraduate course in *Gynecological Pathology, Cytogenetics and Endocrinology,* at Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Feb 13-14: Wisconsin Chapter, American College of Emergency Physicians, Alpine Valley Resort, East Troy. Subject: Cold injuries—recreational and industrial.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835. ■

FALL REGIONAL CANCER CONFERENCE

Thursday, October 12 • Pioneer Inn, Oshkosh

am		
7:30	Registration	
8:00	Welcome—*Paul P Carbone, MD*	
8:05	Reliable Screens—*Richard R Love, MD*	
8:35	Mammography—*Raul H Matallana, MD*	
9:05	Nuclear Medicine—*Robert E Polcyn, MD*	
9:35	CT Scanner—*George Wirtanen, MD*	
10:05-11:05	Breast Workshop Group A *Alvin J Greenberg, MD* Chairperson *Robert O Johnson, MD* *Raul H Matallana, MD* *Douglass Tormey, MD*	Lung Workshop Group B *John R Pellett, MD* Chairperson *Ernest C Borden, MD* *Joyce C Kline, MD*
11:20-12:10	Repeat Workshop Group B	Repeat Workshop Group A
pm		
12:30	Luncheon—*John R Milbrath, M.D.*	
2:00-3:10	Gastrointestinal Workshop Group A *William H Wolberg, MD* Chairperson *Hugh L Davis, MD* *Albert L Wiley, MD*	Gynecology Workshop Group B *Dolores A Buchler, MD* Chairperson *Thomas E Davis, MD* *Mojmir G Sonek, MD*
3:10-4:20	Repeat Workshop Group B	Repeat Workshop Group A

Acceptable for 6 credit hours of Category I of AMA-PRA.

INFO: Registration deadline, Oct 2, 1978: $10.00 per person. Make check out to Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

American Society of Internal Medicine Future meetings:

Sept 26-29, 1978 .....Interim Meeting .....Orlando, Florida

April 26-29, 1979 .....Annual Meeting .....New Orleans, Louisiana

Sept 28-29, 1979 .....Interim Meeting .....Las Vegas, Nevada

May 15-18, 1980 .....Annual Meeting .....Washington, DC

Sept 26-27, 1980 .....Interim Meeting .....San Diego, California

April 30—May 3, 1981 .Annual Meeting .....Denver, Colorado

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WHAT'S NEW IN EMERGENCY MEDICINE

also featuring cost-containment measures

presented by

Wisconsin Chapter, American College of Emergency Physicians

Friday-Saturday/October 27-28
Red Carpet Inn, Milwaukee

Guest speaker:
Donald Kunkel, MD, JD
Phoenix, Arizona

Program followed by Annual Meeting and Election of Officers

Further info: C Randolph Turner, MD, President, 7335 Maple Terrace, Milwaukee, Wis 53213.

Fall Cancer Conference

Saturday, September 30, 1978

Clinical Sciences Center
600 North Highland Avenue
Madison, Wisconsin

Program

8:00 Registration
8:50 Welcome—Paul P Carbone, MD
8:51 *Cancer Control and the Practicing Physician:* R O Johnson, MD
9:00 *Screening for High Risks:* Richard Love, MD
9:20 *Prostate Cancer Dx and Rx:* Ralph C Benson, MD
9:40 *CT Scanner—Its Role in Radiotherapy:* George W Wirtanen, MD
10:20 *Hyperthermia and Cell Sensitizers with Radiation:* William L Caldwell, MD
10:40 *The Problem of Environmental Carcinogens:* Henry Pitot, MD
11:00 *New Drugs in Cancer:* Robert H Earhart, MD
12:00 Lunch: CSC Cafeteria

Further information contact: Ms Millicent Baltus, American Cancer Society, Wisconsin Division, 608/249-0487.

Medical College of Wisconsin

annual postgraduate course

GYNECOLOGICAL PATHOLOGY, CYTOGENETICS AND ENDOCRINOLOGY

Pfister Hotel and Tower
Milwaukee

Thurs-Wed, Jan 4-10, 1979

Six-day course has been extended to include a complete up-to-date review of endocrinology and cytogenetics in addition to a thorough resume of gynecological pathology. Designed primarily as a postgraduate refresher course for residents, practitioners and specialists desiring a current review of the pathology of the reproductive tract.

Guest faculty: *H W Jones, Jr, MD; Georgeanna S Jones, MD; E R Novak, MD; J D Woodruff, MD;* and *C Julian, MD.*

Space limitation requires registration for the entire course. Limited to 150 registrants.

Course is approved for 55 cognate hours of prescribed credit by PRA-AMA.

Enrollment fee, $400, includes 68 selected 35 mm slides.

Info and registration: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

CONTRIBUTIONS—CES FOUNDATION
June 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1978.

Unrestricted

Waukesha County Medical Society Auxiliary—*Voluntary Contribution*

Restricted

Community Medical Group-Mondovi; Doctors Clinic of Elkorn; WE Rosenkranz, MD; Drs Handyside & Bates; Medical Associates-Baraboo; Francis Gilbert, MD; John S Honish, MD; Forrest E Zantow, MD; Family Medical Clinic-Merrill; MW Asplund, MD; JE Geigler, MD; Red Cedar Clinic-Menomonie; Dodgeville Clinic; Wisconsin Rural Rehabilitation Corporation; General Clinic-Antigo; RM Nesemann, MD; Goldberg Medical Clinic-Milwaukee; Elmbrook Memorial Hospital-Brookfield; Falls Medical Group-Menomonee Falls; Hayward Medical Group; RK Chambers, MD; Osseo Medical Center—*Medical Student Summer Externship Program*
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Schrank Clinic Doctors & Staff—*Edward Pettack*
State Medical Society—*George J Schroth, MD; Lynn J Wacker, MD; Karl E Kassowitz, MD*

5.08% MEDICARE, MEDICAID CHARGE INCREASE ANNOUNCED

The Department of Health, Education, and Welfare has announced an increase in the prevailing charges for physicians' services under Part B of the Medicare (Title 18) Program. The allowable prevailing charges through June 30, 1979 will be 1.426 as compared to 1.357 used for the previous 12 months. This is an increase of 5.08 percent over the last fiscal year. This means that the prevailing charges for physicians' services to be used during the 12-month period beginning July 1, 1978, may not exceed the prevailing charges in effect on June 30, 1978 by more than 42.6 percent. The same prevailing charge increase will be applicable to the Medicaid (Title 19) Program since it reimburses physicians' services on the basis of the same profile data as used by Title 18.

ANALYSIS OF MENTAL HEALTH RECORDS LAW AVAILABLE

The State Legislature last session made several changes in the law pertaining to mental health record access. The law affecting these records has become increasingly complex over the past few years, and is not easily found in one section of the state statutes or through administrative rules. It is based, instead, on a number of Attorney General opinions, state regulations, and state statutes. Section 51.30 Wisconsin Statutes is an attempt to codify other areas of medical records law. This new law was analyzed recently at a conference held by the Center for Public Representation and a copy of this analysis is available to any physician interested in finding out how the law may affect his/her practice. For copies, contact the SMS Quality Care Division at SMS headquarters in Madison.

CHANGES IN PRIOR AUTHORIZATION REQUIREMENT ANNOUNCED

Effective June 15, 1978, physicians must obtain prior authorization for all prescriptions for methaqualone for medical assistance patients from the State Bureau of Health Care Financing. This policy is based on the judgment of the Bureau's medical consultants that methaqualone is seldom, if ever, the drug of choice and has a high potential for abuse. The Controlled Substances Board has encouraged the Bureau to take this action. The procedure for obtaining prior authorization will be identical to that used for other drugs requiring prior authorization. The prescriber should submit the request on form PA/HCF 6-1, to which form PA/HCF 6 has been attached. The prior authorization requirement will apply to both methaqualone and its salts, including but not limited to the following brand name products: Aqual, Optimal, Parest, Quaalude, Somnofac, Sopor, and Tuazole.

AMA RESPONDS ON BAKKE DECISION, MINORITY MEDICAL STUDENTS

In response to the Supreme Court ruling, "Regents of the University of California *v* Bakke," CH William Ruhe, MD, Senior Vice President of the AMA, made the following comments on behalf of the Association. "The AMA has long been in support of programs designed to increase minority representation in medical schools and in the practice of medicine. This position was reaffirmed at the AMA's annual meeting last June through acceptance of a manpower report of the AMA Council on Medical Education. The report addresses the issue of "Black and Other Minority Group Physicians" with the opening statement: 'The inadequate representation of minority groups in the medical profession and in medical school enrollments remains of concern to the AMA.' The Supreme Court ruling seems to permit medical schools to continue using race as one factor in determining admission criteria. We hope that medical schools will, therefore, continue to use those selective admissions programs designed to increase the numbers of minority students. It is only through these types of programs that we can hope to increase the numbers of minorities in the practice of medicine." ■

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Created by the Territorial Legislature in 1841

Representing 4,600 member physicians in Wisconsin, comprising 55 county medical societies, with all members belonging to the American Medical Association.

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Further information on the Society structure and its functions appears annually in the June BLUE BOOK issue of the *Wisconsin Medical Journal,* the official publication of the Society.

STATE MEDICAL SOCIETY OF WISCONSIN
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1903 1978 75th ANNIVERSARY YEAR

USPS 688-360
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Journal Established 1903

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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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1978 STATE HEALTH PLAN OKAYED BY HPC

Final approval was given a five-year State Health Plan by the Wisconsin Health Policy Council at its August 24-25 meeting in Madison. The Plan is required by the Federal Health Planning Act and must be updated annually. In drafting and public hearing processes during the past year, the Plan incorporates several goals, objectives, and recommendations in the following service areas: general medical services, surgical services, radiology, pathology and laboratory services, obstetrical-perinatal services, mental health services, dental services, community health education, vision care services, maintenance services, health system enabling services, habilitation and rehabilitation services, health-care support services, and prevention and detection. The Plan is advisory to the Governor, the Legislature, and the Department of Health and Social Services, but is expected to be influential in state program and budget planning as well as at the local HSA (Health Systems Agency) level. Further details of the SMS involvement with the Plan will appear in the October issue of WMJ.

EDS-FEDERAL BEGINS PRE-JULY 1 PAYMENTS OF T-19 CLAIMS

At the direction of the State Division of Health EDS-Federal Corp on the first of September began issuing checks for pre-July 1, 1977 T-19 claims. This first of several "check-writes" involved 191,-000 claims totaling more than $6 million. Deducted from this check-write were nearly $2 million in cash advances. EDS-F has utilized a payment methodology that gives the benefit of the doubt to the provider whenever the claim was delayed because of a problem in determining recipient eligibility. DHSS Deptuy Secretary Terry Willkom presented this methodology in detail to the SMS Physicians Alliance staff early in September. Physicians desiring more information or who have questions concerning this matter should contact the SMS Physicians Alliance staff at toll-free 1-800-362-9080.

OPHTHALMOLOGISTS MEET WITH DEAN ON OPTOMETRIC DRUG LAW

Sarah Dean, secretary of the Department of Regulation and Licensing, met for the second time with Walter Gager, MD, Brookfield, and Arthur Tacke, MD, Milwaukee, cochairmen of the SMS Section on Ophthalmology and other ophthalmologists to discuss the progress in the development of administrative rules for new optometric drug law. Topics of discussion included: what drugs will be approved for use by optometrists; the requirement for all optometrists to have a referral system for patients who suffer adverse reactions to ocular drugs; the course content of the 60-hour pharmacology requirements that optometrists must complete before they may use ocular drugs; and the examination requirements. Ms Dean indicated that the final draft of the rules will be completed by the last week in August, and the Department ofRegulation and Licensing then will hold public hearings on the rule draft. After the hearings, the Department can revise the rules based on the hearing testimony and send them on to legislative committees for review. Copies of the rules will be available from the SMS Quality Care Division in Madison.

COUNCIL INITIATES NEW PEER REVIEW FOUNDATION

A new peer review organization, called the "Wisconsin Review Foundation," was initiated by the SMS Council August 5 to undertake review of the medical care of private paying patients in Wisconsin. See details in SMS ORGANIZATIONAL section of this issue.

COUNCIL VOICES SUPPORT FOR UW FAMILY PRACTICE PROGRAM

The SMS Council continued its strong support for the UW Family Practice Program when it passed a resolution August 5 urging the University to select a Family Practitioner to head the Department and to have the State Medical Society and the Wisconsin Academy of Family Physicians participate in any committee formed to review the Family Practice Program. See details in SMS ORGANIZATIONAL section of this issue. ■

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Family Practice Residencies

THE HEAD OF THE Family Practice Residency Program at the University of Wisconsin-Madison recently resigned at the request of the Medical School Dean and the Chancellor at the University. When asked to comment on the subject, Acting Governor Martin Schreiber prudently declined to intervene and indicated that the State Capitol was at one end of State Street and the University was at the other.

The Council of the State Medical Society, with equal prudence, reaffirmed its longstanding support for a strong Family Practice Program at the University and asked for a role in any proposed evaluation of the current program. This show of support for the future of the program involves, as it should, policy rather than personalities.

It must be recognized that the Family Practice Department is part of the Medical School and the Medical School is part of the University of Wisconsin. Thus, its administration is the domain of the University and not of the State Medical Society. The termination of the chairmanship of the department certainly does not terminate the program and assuredly the Family Practice Residencies will continue in the future. The Society's leadership and its members should take great interest in encouraging their success.—VSF

Cutting dues for new practitioners

IN VOTING A 50-percent, one-year cut in AMA membership dues for physicians first entering practice, the Association's House of Delegates did a good turn for all physicians.

The reduction will manifestly bring in more new practitioners, thus giving the AMA a broader base of support and making it more truly representative of the medical profession.

Consequently, the AMA will be even more effective as an organization that sets and protects medical standards, strives for more and better public health, and represents doctors in coping with government, insurers, hospitals, and the media.

(The State Medical Society of Wisconsin already has a 50% first-year dues reduction available for an MD who joins SMS within two years of date of completion of internship or residency. See article in the SMS ORGANIZATIONAL section of this issue.)

The dues cut—adopted at the Association's annual convention in June—means physicians during their often hard-pressed first year of practice will be paying $125 as contrasted with the $250 regular dues and the $35 paid by housestaff.

The membership gain resulting from the dues cut is expected to reach almost 5,000 in five years.

Increased enrollment by physicians of all ages, and in all branches of medicine, is needed if our federation—numerically and financially—is to sustain its strength in the face of constant challenges.

A survey cited in a Board of Trustees report to the House showed that the $250 dues—rather than any lack of awareness of AMA activities—have been a major obstacle to new-practitioner membership.

The report said:

"Ninety-three percent of nonmember students, 85 percent of nonmember residents, and 88 percent of nonmember practicing physicians have specific perceptions of what the AMA does as an organization. For the most part, these perceptions center around lobbying, representing doctors, and medical-education activities."

On the other hand, only 31 percent of the residents surveyed (members and nonmembers) said they would sign up at the $250 rate, as compared with 42 percent at the $125 rate.

So in numerous instances, the $125 rate will stimulate retention of housestaff and students who have increasingly poured into the AMA since its doors opened to them in 1972 and 1973 respectively. Their combined dues-paying membership jumped from 3,000 in 1973 to 28,094 last year.

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In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

They've had the opportunity to see how effective the federation is, and to be influential in that effectiveness. In government and elsewhere, the AMA is respected or attacked chiefly because it is medicine's only general spokesman and doer. And the younger physician's contribution to our impact dates back to our Association's very beginning.

It goes back most notably to Dr Nathan Smith Davis, who was only 29 when he spun the organizational wheels that made him "the Father of the American Medical Association."

All of us should endeavor to bring more young physicians into the AMA and our state and county medical societies—to help ensure the future vitality and stamina of organized medicine. ■

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History

The Wisconsin Medical Journal, 1903

Victor S Falk, MD, Medical Editor

VOLUME I, No. 1 of the *Wisconsin Medical Journal* appeared on January 1, 1903. Arthur J Patek, MD was the original editor. Later in the same volume it was noted that he had been appointed Physician to the Milwaukee Hospital and that he was President of the new Jewish Hospital staff in Milwaukee ("the hospital is to be free to all as nearly as practicable"). Otto H Foerster, MD, premier Milwaukee dermatologist, was the associate editor.

There was only a single page of advertising in the entire first volume (see reproduction at right). There also was a notice that the Kremers-Urban Pharmaceutical Chemists and Physicians Supply House had moved to commodious downtown quarters on East Water Street in Milwaukee. "Our readers will find the latch string out and a hearty welcome by the genial members of this enterprising firm at all times."

Many famous and familiar names were encountered in Volume I. On page 1 was an article by John B Deaver, MD of Philadelphia entitled "Acute Intestinal Obstruction Following Operation for Acute Appendicitis." The paper concluded that "the patient was well shocked toward the conclusion of the operation and 2,000 cc's of saline solution were given intravenously." This is the only report of fluids being given intravenously although in many of the other papers there was mention of saline infusions by hypodermoclysis. Another famous name was that of Chaddock (Chaddock's sign) who had a paper on "Salicylate of Soda in the Treatment of Basedow's Disease" (an old term for exophthalmic goiter). He quoted the favorable results from Babinski of Paris using the same treatment. Another name was Arthur Dean Bevan who wrote on "The Surgical Treatment of Anuria." Doctor J B DeLee had a paper on "Rupture of Uterus During Labor." Trendelenburg wrote from Munich on the "Cure of Extrophy of the Bladder with Continence of Urine." Channing commented on the "Mental Status of the Assassin of President McKinley" and concluded that insanity appeared to be the most reasonable and logical explanation

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of the crime. The proceedings of the Chicago Surgical Society reported that the President, Doctor John D Murphy, was in the Chair and that Doctor E J Senn read a paper on "Transplantation of Omentum in the Operative Treatment of Intestinal Defects." Coley (of Coley's vaccine) reported on results of his treatment using x-ray in 75 cases of malignant tumors. He concluded that x-ray treatments "should be limited to inoperable cases and to cases after operation as a prophylactic measure."

In addition to the original scientific articles, many originating outside of the state, there was a monthly Correspondence Section. This usually included a Chicago Letter, a Baltimore Letter, and a Philadelphia Letter. The current medical literature, subdivided into specialties, was abstracted from national and international journals by Wisconsin physicians.

There was news of the medical societies within the state. The Central Wisconsin Medical Society and the Fox River Medical Society both voted to affiliate with the State Medical Society according to a plan of reorganization of the American Medical Association. Prior to 1903 the State Medical Society meetings were attended only by delegates from the county medical societies. The State Medical Society meeting in June 1903 was held in the arcade of the Plankinton House in Milwaukee. A smoker was tendered the visitors by the Milwaukee Medical Society at the Society rooms in the Goldsmith Building.

The State Board of Medical Examiners assembled in Milwaukee to investigate the charges of violation of the State Medical Law made by the Milwaukee Medical College against the College of Physicians and Surgeons. After some "preliminary skirmishing, in which nothing of importance was developed" the charges were withdrawn. However, the judicial council of the Association of American Medical Colleges reported the charge of irregularities preferred by the Medical Society of Milwaukee County against the Milwaukee Medical School had been sustained. They recommended that the College be indefinitely suspended from membership in the association. A plea of leniency was made by the President of the Wisconsin College of Physicians and Surgeons and by the President of the Chicago Medical Society. The vote was reconsidered and the college was "severely censured."

The smallpox epidemic in Milwaukee in 1902 was reported to be relatively mild although 236 cases were reported with only one death. The Registrar of Vital Statistics suspected that many cases were not reported prior to recovery because patients feared going to a hospital which they thought of as a "pest house." Vaccination and re-vaccination was urged by the officer. The Commissioner of Health in Milwaukee was agitating again for the passage of an Anti-spitting Ordinance. Also, in Milwaukee Mr H H Camp gave his "magnificent and spacious residence on Tenth Street, near Wells, to the Children's Hospital Association to be used for hospital purposes."

Doctor Reginald Jackson, one of the founders of the Jackson Clinic at Madison, read a paper before the Central Wisconsin Medical Society entitled "Ectopic Gestation." He concluded with a cardinal rule: "In every case of abdominal affection in a woman, first to think of and then eliminate, by a thorough examination, the possibility of an ectopic gestation." Doctor Nahin of Milwaukee found one of the most perplexing difficulties in the treatment of appendicitis is obstinate constipation. He found it necessary to "unload the bowels" and used "colonic pumping with flattering results." He advocated introducing high up into the colon a flexible rubber pump from two and a half to three and a half feet. He then injected a solution of magnesium sulphate, glycerine, and lukewarm water; and if there was much tympanitis, spirits of turpentine was added. He assisted the escape of the watery stool by alternately compressing and relaxing the air bulb. This was followed by a salt solution injected as many times as necessary. He said this "could be repeated twice a day if necessary without any inconvenience to the patient and with no disturbance of the inflamed parts and the much desired plastic peritonitis is favored." He agreed that it was true that it was a very unpleasant procedure for the physician but thought the results were amply compensating. The possibility of ureteral catheterization was discussed. Solid sounds—preferably metallic—were to be used. Flushing out of the renal pelvis with a solution of silver salts of non-irritating character was reported to be very gratifying in cases of pyelitis. A new silver salt called Argyrol was reported successful in the treatment of gonorrhea. A paper entitled "A Study of Two Cases Nourished Exclusively Per Rectum" that had been read before the College of Physicians of Philadelphia was reproduced.

This retrospective review of the earliest *Wisconsin Medical Journal* has been a nostalgic experience. Some of the reports are almost ludicrous in light of 75 years of medical progress—yet some of the conclusions and controversies could have been only yesterday. ■

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Pfizer's comprehensive certificate of need assistance program available to hospital administrators

A new Certificate of Need (C.O.N.) Assistance Program is being offered to hospital administrators and the hospital community, it was announced today by Dr. Sheldon G. Gilgore, President, Pfizer Pharmaceuticals & Diagnostic Products, Pfizer, Inc. Dr. Gilgore further stated that a toll-free telephone consultation service—which is part of this Comprehensive Assistance Program—will offer the hospital administrator direct and immediate access to expert consultation on the medical needs and cost effectiveness of major diagnostic equipment, and the relevance of this information to C.O.N.

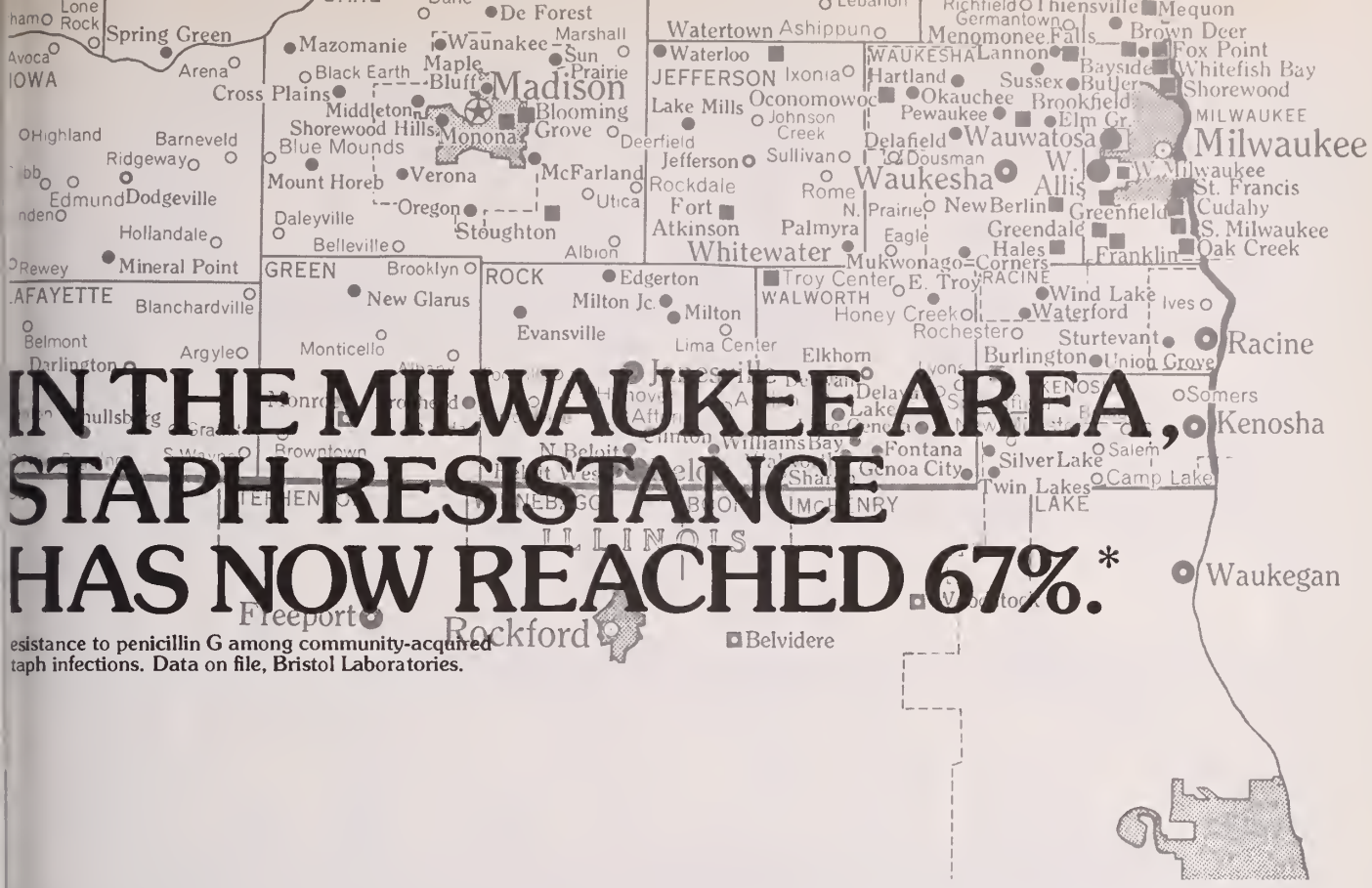
The C.O.N., one of the primary Federal and State regulatory requirements, is usually needed whenever plant improvements or major capital equipment expenditures involve government health care funds. Filing for a C.O.N. can be a complex and time-consuming process, and the hospital administrator's task is further complicated by the fact that C.O.N. programs vary significantly.

Another important aspect of Pfizer's C.O.N. Assistance Program is the book—"Certificate of Need: An Expanding Regulatory Concept." This 944 page book—provided complimentary to the hospital administrator by Pfizer—is a comprehensive, state compilation of C.O.N. requirements. This unique text will provide additional support for major capital equipment procurement decisions.

This vital reference source together with the toll-free telephone service will allow the hospital decision maker purchasing Pfizer and any other manufacturers equipment to cope more effectively with the complex C.O.N. regulatory machinery. The convenient C.O.N. service can be reached from 9-5 Monday through Friday by dialing toll-free 800-638-9690.

Dr. Gilgore summarized by emphasing that this new C.O.N. program for hospital administrators is but another example of Pfizer's 129 year history of offering high quality products and vital services to the health care community.

"This new Pfizer C.O.N. Assistance Program will prove a valuable aid to the hospital administrator by answering questions on medical need and cost effectiveness of diagnostic equipment such as ours; and how this information can relate to C.O.N. preparation, documentation, filing, and application amendment where necessary." ■



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Cancer epidemiology

Part IV

Lung Cancer

LUNG CANCER is the number one cause of cancer deaths in men.[1] It ties with colorectal cancer for the greatest number of new cases estimated for 1978 (excluding common skin cancers). It accounts for 22% of all male and 7% of all female malignancies.[2] The incidence rate for both men and women (black and white) has more than doubled. In the last 45 years the death rate for men has increased more than 25 times. For most counties in Wisconsin, lung cancer mortality is significantly lower than that found in the rest of the United States.[3] The current national five-year survival rate for lung cancer is 8% for men and 12% for women, which is up only slightly from the last decade.[4]

Lung cancer mortality rates among the lower socio-economic groups are from 2.6 to 3.8 times higher than those for the higher socio-economic groups. It has not been possible to show any significant association between economic class and smoking or differences in medical treatment between the two groups;[5] therefore, additional factors must be found to explain this difference.

Smoking has been strongly associated with lung cancer as well as with other malignancies of the respiratory and upper gastrointestinal tract. It is the greatest risk factor for the development of lung cancer; smokers have a risk between 10 and 50 times that of the non-smoker.[6] The variation in risk is directly related to the amount smoked. A man who has smoked over 40 cigarettes a day for over 40 years has 5.5 times the risk of a person who never smoked. A woman who has smoked 20 or more cigarettes a day for over 40 years has 2.2 to 4.8 times greater risk.[7] Women are smoking more heavily at younger ages, so they are developing more cancer.

The beneficial effect of stopping smoking is also dependent upon the number of cigarettes previously smoked each day. However, it has been observed that even among the heaviest smokers, the risk of developing lung cancer returns to that of the nonsmoker 10 years after cessation of smoking.[8,9] This was demonstrated in England during the 1950s and early 1960s when many British physicians stopped smoking. While the mortality rate for lung cancer among English men rose 7% during this time, British doctors experienced a 34% decline in mortality.[10]

The average age at onset is approximately 60 years, with the peak incidence between 50 and 60 years. However recent statistics include more younger people. It is more common in scarred and chronically diseased lungs.

When environmental exposure to air pollutants as well as job-related exposure was studied to determine the relationship of air pollution to lung cancer, there were no differences in rural-urban lung cancer rates detected when the studies were controlled for smoking.[2] This would indicate that air pollution in urban areas has little or no effect on lung cancer rates. Asphalt workers, painters, leather workers, carpenters, miners of many types of metal, and people who work with strong chemicals develop more lung cancer. Exposure to asbestos, uranium, or chromates, especially if one smokes, also increases the risk.[11,12] Radiation due to radioactive uranium dust, atomic bombs, radon and pitchblend-containing ores, and diagnostic radiation for certain conditions of the spine increases the risk.

REFERENCES may be obtained by request from the Wisconsin Clinical Cancer Center

—JANE HARBERG
DOROTHY J BUCHANAN-DAVIDSON, PhD

Asbestos awareness

Many Wisconsin citizens may be at special risk of developing lung cancer, cancers of the digestive system, mesothelioma, or asbestosis because of exposure to asbestos. Especially at risk are persons who work in shipyards, mine asbestos, manufacture or install insulation, and repair automotive brake linings. Many people previously employed in shipyards or who worked near areas contaminated with asbestos dust appear to be developing abnormalities typical of asbestos exposure which can be detected on x-ray film. The amount and length of exposure are important.

Asbestos has about 3,000 different uses; however, it is the fine fibers which pose the greatest threat. Once incorporated into manufactured items, the hazard is less serious, unless the fibers are set free.

Among workers exposed to asbestos, about 20 to 25% of all deaths are due to lung cancer, compared to 4 to 5% in the general population. Asbestos workers who smoke have eight times the risk for lung cancer that other smokers have. Quitting smoking can reduce the risk. There are also indications that mesothelioma, a cancer affecting the pleura or the peritoneum, is becoming more common.

The first symptom of asbestosis (a chronic lung disease) is usually shortness of breath on exertion. This is normally not observed until at least 10 years after exposure, often 35 or more years. Usually the disease must be rather advanced to produce shortness of breath. Rales is the most characteristic physical sign. Late symptoms are clubbing of the fingers and bluish discoloration of the skin, lining of the mouth, and tongue. X-ray films will show diffuse scarring of the lungs, and lung function tests will show reduction of the volume of air that can be inhaled. Asbestosis does not necessarily lead to lung cancer but indicates increased risk of asbestos-associated cancers.

Workers who may have been exposed to asbestos should be examined carefully and have a chest roentgenogram, lung function test, rectal examination, and possibly sputum analysis. Early roentgenographic changes often precede more serious consequences.

Additional information concerning medical problems associated with occupational exposure to asbestos can be obtained from the Clearinghouse for Occupational Safety and Health Information, 4667 Columbia Parkway, Cincinnati, Ohio 45226, or by calling the Cancer Information Service toll-free at 1-800-362-8038.

—DOROTHY J BUCHANAN-DAVIDSON, PhD

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

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Council sets up new medical peer review foundation

At its August 5 meeting in Madison the Council, in response to the House of Delegates action April 15, 1978, initiated a statewide network to review the health care provided to private patients.

An organization to be known as Wisconsin Review Foundation was established by the State Medical Society in concert with hospital, professional standards review organizations, insurance, labor, and business interests.

The foundation has two primary goals: 1) to evaluate modes of physician practice and make improvements in quality where necessary, and 2) to help contain the costs of health care by impacting on unnecessary services, over-utilization, or inappropriate care.

In a meeting at the SMS headquarters in Madison September 6, a 25-member board was established to direct the foundation. President of the new foundation is Paul G LaBissoniere, MD, Milwaukee. Other officers are: Donald Orleans, Manitowoc, vice-president; Blake E Waterhouse, MD, Madison, secretary; and Jack Matheus, Milwaukee, treasurer. The executive director is Cameron G Brown, Madison.

The foundation expects to be operational by Jan 1, 1979. Its activities will supplement similar review activities undertaken for hospitalized patients covered by Medicare and Medicaid whose review is conducted by the Foundation for Medical Care Evaluation (FMCE) in seven southeastern counties, and by the Wisconsin Professional Review Organization (WisPRO) in the remaining 65 counties of the state.

Hospitalized nongovernment patients will be the first target of Wisconsin Review Foundation. The new foundation, to assure a total evaluation of private patient care in Wisconsin, will move rapidly into review of clinic and solo physician medical practice and later into such areas as nursing homes and home care.

The Wisconsin Review Foundation is unique nationally in that it represents a totally voluntary effort on a statewide basis by health professionals to assure accountability for medical services.

Eight organizations form the consortium which will operate the new review foundation. They are: State Medical Society of Wisconsin, Wisconsin Association of Osteopathic Physicians and Surgeons, Foundation for Medical Care Evaluation of Southeastern Wisconsin, Wisconsin Professional Review Organization, Wisconsin Hospital Association, Blue Cross of Wisconsin, Surgical Care Blue Shield, and Wisconsin Health Insurance Council.

Members of the Board of Directors of Wisconsin Review Foundation, Inc and the organization they represent are:

State Medical Society of Wisconsin: Antoine Barrette, MD, Peshtigo; Thomas J Doyle Jr, MD, Eau Claire; Paul G LaBissoniere, MD, Wauwatosa; Rocco Latorraca, MD, Wauwatosa; Jules D Levin, MD, Milwaukee; Johan A Mathison, MD, Oshkosh; Richard C O'Connor, MD, Wausau; John D Riesch, MD, Menomonee Falls; William Rock, MD, Madison; Robert A Starr, MD, Viroqua; Blake E Waterhouse, MD, Madison; and Earl R Thayer, Madison.

Foundation for Medical Care Evaluation of Southeastern Wisconsin: Robert R Cadmus, MD, Milwaukee.

Wisconsin Professional Review Organization: John K Scott, MD, Madison.

Wisconsin Association of Osteopathic Physicians & Surgeons: Kenneth J Kurt, DO, Elm Grove.

Wisconsin Hospital Association: Donald Orleans, Holy Family Hospital, Manitowoc; Kenneth Van Bree, Divine Savior Hospital, Portage; and Karl York, St Luke's Hospital, Racine.

Service insurance corporations: Robert C Haskins, Blue Cross of Wisconsin, Milwaukee; and Thomas H Girard, Surgical Care Blue Shield, Milwaukee.

Private health insurance carriers: Lloyd F Mathwick, Employers Insurance of Wausau, Wausau; and Roger R Rheeling, Rural Insurance Companies, Madison.

Public representatives: John W Matheus, Allen-Bradley Company, Milwaukee; and John W Schmitt, Wisconsin State AFL-CIO, Milwaukee.

Appointment of the 25th member of the board is pending. ■

SMS Annual Meeting Scientific Program plans underway

The State Medical Society's Commission on Continuing Medical Education has begun making Scientific Program plans for the May 10-12, 1979 SMS Annual Meeting.

The Commission has approved the following panels for presentation at the 1979 Annual Meeting in Milwaukee: Friday, May 11—"Prostatic Carcinoma" and "Practical Aspects of Immunology; Saturday, May 12 — "Obesity" and "Low Back Pain."

SMS Specialty Sections and Wisconsin Specialty Societies are reminded that the deadline for their finalized programs to the Scientific Program Committee is November 1.

Please direct your responses to: Arlene K Meyer, Continuing Medical Education, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701 (toll free line: 1-800-362-9080). ■

Other Council highlights

● Adopted a resolution that the State Medical Society of Wisconsin: 1) continue its support of a strong **Family Practice Residency Program** in Wisconsin to assure that adequate hospital facilities and health care providers are available on a local level;

2) recommends to the University of Wisconsin, and the Legislature if indicated, that the SMS and the Academy of Family Physicians participate in any committee formed to review the program; and

3) recommends the selection of a *family practitioner* to head the Department of Family Medicine and Practice at the UW Medical School.

● Adopted a **Statement of Interprofessional Relations** between physicians and physical therapists recommended by the SMS Commission on Health Planning. (Copies are available from the Quality Care Division of SMS in Madison.)

continued next page

Continued

- Added new members representing the state specialty societies and SMS scientific sections to the SMS **Commission on Health Planning.**

- Approved production of a **"Partners in Good Health" brochure,** a project of the SMS Commission on Public Information, which will be available this fall to SMS members upon request, for placement in reception rooms, statement stuffers, and other patient distribution. The brochure informs patients of important elements in a good doctor-patient relationship.

- Approved **"Planning and Implementing a Health Promotion Program,"** a paper by Terry Hankey, MD, Waupaca, which outlines a health promotion program that physicians can use to help their patients achieve a more healthful lifestyle. (The article will appear in the October issue of WMJ.)

- Elected James T Houlihan, MD of Woodruff to the SMS **Commission on Continuing Medical Education.**

- Adopted a policy statement regarding **Health Screening Treatment and Education Programs** that large scale health screening and diagnostic tests should not be undertaken unless there is an acceptable cost-benefit ratio. Criteria were developed by the Task Force on Health Screening and Immunization in response to a directive from the 1978 House of Delegates (Resolution 36).

- Directed that DHSS and EDS be informed that the January 1, 1979 deadline for the mandatory use of the **uniform claim form** is unacceptable and unrealistic, and should be delayed at least until July 1, 1979, to give time for orderly implementation in a physician's practice.

- Approved support for a proposal being considered by Wisconsin Health Care Liability Insurance Plan (WHCLIP) for a **claims review and risk management program** operated by Medical Liability Consultants of Colorado. The Council further authorized the Medical Liability Committee of the Physicians Alliance Commission to act in negotiations on a pilot program for Wisconsin.

- Requested that an alternative approach be developed with radiology to the concern of **limiting population exposure to ionizing radiation,** which was believed to be the intent of a section in the 1978 State Health Plan that proposed continuing education requirements in connection with the use of diagnostic x-ray.

- Set Saturday, October 28, at 9:00 AM as the date for the next Council meeting in Madison, with committee meetings the day before. ■

Attention physicians: Reduced practice membership classification

The Society reminds physicians who have reached age 65 and practice 1,000 hours or less during the calendar year, but do not qualify for associate membership, may apply for a "senior" membership which waives 50 percent of the regular membership dues.

This special membership classification must be applied for through the physician's county or state society. The change will become effective January 1 following receipt of the request.

In addition, the Society reminds physicians who are over 70 years old that they are not required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

The dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification (less than 240 hours of practice per year) which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged. ■

New membership classifications for young physicians

Many young physicians now are eligible for a special membership classification at the State Medical Society which carries with it a reduction in membership dues.

Any physician who has been a member of a state medical society for the preceding 12 months and is elected to membership in this society within six months of completing residency, fellowship, or fulfillment of government obligation enjoys a dues reduction of 50 percent the first year and 25 percent the second year.

This society and most other state medical societies have a special membership classification for Residents which has a very low dues structure.

The AMA, to attract new members, recently adopted a new physician membership classification. Under this new membership classification a physician in his first full year of practice is eligible for a 50 percent reduction in AMA dues for one year.

It behooves each physician to seriously consider joining organized medicine now and take advantage of these special membership rates. ■

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SMS, Auxiliary help launch massive immunization campaign

The State Medical Society and its Auxiliary are participating in a major campaign with the Wisconsin Department of Health and Social Services and McDonalds restaurants in Wisconsin to have all children in Wisconsin properly immunized before school starts in the fall of 1979.

Starting September 1 McDonalds began promoting use and distribution of 1.2 million immunization award certificates which when filled out and signed by a physician, nurse, or authorized person from local health departments, provides a tear-off coupon redeemable at all Wisconsin McDonalds restaurants for a free hamburger. The certificate serves three purposes: 1) It's an award to a child who is current on his/her immunizations; 2) It's a record of immunizations; 3) It's a reward to the child in the form of the free hamburger.

The SMS Auxiliary has agreed to help promote and distribute the certificates to physicians' offices. In late August all SMS physicians received a letter from the Auxiliary detailing the campaign along with sample award certificates. To order more certificates for your office contact the SMS Auxiliary headquarters in Madison or your local county medical society auxiliary president.

Physicians are urged to order adequate supplies of the certificates for their offices, to display them prominently in their patient waiting rooms, and to consult with patients concerning their children's immunization status. Local SMS Auxiliaries will be contacting physicians regarding their cooperation with the immunization effort, as well as promoting the use of tickler files in physicians' offices, and audit stickers on the front of patient records for recording immunization status. These audit stickers may be ordered in any quantity from the Division of Health Immunization Program, PO Box 309, Madison, Wis 53701, at no charge. ■

New immunization requirements established

WINK! Wisconsin Immunization Now for Kids! is the central theme for an intensive statewide program to raise immunization levels above 90% by October 1979. This effort, of which the State Medical Society is a participant, is part of the National Immunization Initiative announced by HEW Secretary Califano in the spring of 1977.

Wisconsin has the dubious distinction of being the state which for the first half of 1978 has reported the third highest number of both measles and rubella cases, the sixth highest number of mumps cases and the 13th highest number of pertussis cases. Even more disturbing is the fact that the majority of these cases is occurring among school-aged children who should have been immunized long before they even entered school.

To eliminate the continuing outbreaks of vaccine-preventable diseases among Wisconsin students, minimum immunization requirements have been established for all students in kindergarten through twelfth grade. These requirements will become effective with the beginning of the 1979-80 school year.

Grade	*Vaccines*
K	1 measles, 1 rubella, 4 polio, 4 DTP/Td
1-6	1 measles, 1 rubella, 3 polio, 3 DTP/Td
7-9	1 measles, 3 polio, 3 DTP/Td
10-12	1 measles

The intervening 1978-79 school year, before the requirements take effect, will be used by school officials, working with public health agencies and volunteers, to review the immunization status of each student and notify the parents of those students who do not meet the requirements. Unfortunately, in most Wisconsin schools immunization records are incomplete and for many older students there are no school immunization records at all. In these cases parents will be asked to provide the dates that each required dose of vaccine was administered. Since the parents' records also may be incomplete, many will have to contact their physician for this information. Schools and public health agencies are aware of the tremendous clerical load this places on the physician and his office staff, and will attempt to structure the review process to minimize this problem.

Physician cooperation is requested in providing those parents, who request help, with the month and year of their child's immunizations. The success of this effort will be marked by the end of vaccine-preventable diseases among Wisconsin school children, thus putting us on the very threshold of eliminating many of these diseases. ■

New field consultant named to Fox River Valley Area

Murray E Bevan has joined the State Medical Society as the Physicians Alliance field consultant to the 12 counties in the Fox River Valley area. Bevan, 24, replaces Michael Brozek who is now a legislative coordinator for the Society.

A graduate of Georgetown University and presently a master's candidate at UW-Madison, Bevan joins the Society after working on the Lt Governor campaign in Virginia and interning with Wisconsin Senator William Proxmire. ■

Society names health education coordinator

The State Medical Society expanded its involvement area of health education recently by naming Beth Jones, Antigo, as the new Community Health Coordinator for the Society.

Beth is a recent graduate of UW-LaCrosse in community health education and was an intern at the Society this summer when she designed and implemented a health education program for the Jail Health Care Project on stress management.

Details of her program are being sent to the AMA which plans to distribute the information nationally for use in other jails. ■

JUNE 1978 BLUE BOOK UPDATE

In the listing of Commissions and Committees—1978-1979 on page 86, a member of the Committee on Mental Health, Edward D Meyer, MD, Oshkosh, 1980, was inadvertently omitted. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of Aug 17, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

DANE

Wester, Susan M, 1319 Jenifer St, Madison 53703 (1951, Resident, Pathology)

MARATHON

Heidorn, Richard G, 607 13th St, Mosinee 54455 (1936, Regular, Family Physician)

Jenkins, David D, 2727 Plaza Dr, Wausau 54401 (1947, Regular, Internal Medicine/Hematology)

Maxfield, Barry A, 2727 Plaza Dr, Wausau 54401 (1944, Regular, General Practice/General Surgery)

Stoddard, Steven C, 2727 Plaza Dr, Wausau 54401 (1943, Regular, Orthopedic Surgery)

RACINE

McNeel, Laird, 325 E Jefferson St, Burlington 53105 (1917, Regular, General Practice/General Surgery)

WAUKESHA

Aldrich, Peri L, 434 Madison St, Waukesha 53186 (1952, Resident, Family Physician)

WOOD

Frederick, Thomas B, 402 Wisconsin Ave, Marshfield 54449 (1951, Resident, Internal Medicine)

Martinson, Terry L, 1000 N Oak Ave, Marshfield 54449 (1951, Resident, Internal Medicine)

Stueland, Dean T, 1000 N Oak Ave, Marshfield 54449 (1950, Resident, Internal Medicine)

CHANGE OF ADDRESS

(Does not include those within a city)

BARRON-WASHBURN-BURNETT

Anderson, Robert M, Cumberland, to El Camino Real, Suite 1, Sierra Vista, AZ 85635

Goza, George M, Jr, Cumberland, to 12th & Marshall St, Suite 510, Little Rock, AR 72202

BROWN

Keller, Kent E, Green Bay, to 615 South 10th St, LaCrosse 54601

DANE

Abrahams, Jonathan I, Madison, to RR #5, Box 303, Johnstown, PA 15905

Bernsten, Stephen A, O'Fallon, IL, to 20 S Park St, Madison 53715

Hert, Robert C, Jr, Madison, to 4445 Fleetwood Dr, Manitowoc 54220

Katz, Jordan, Madison, to 3350 LaJolla Village, San Diego, CA 92161

Olson, Janet E, Sun Prairie, to 30 Arch St, Westborough, MA 01581

Suh, Byungse, Madison, to 2430 Terwood Rd, Huntington Valley, PA 19006

EAU CLAIRE-DUNN-PEPIN

Rogers, Jonathan W, Eau Claire, to 2541 Chicago Ave, South, Minneapolis, MN 55404

FOND DU LAC

Bartonek, Victoria D, Ripon, to PO Box 1059, Grants, NM 87020

LACROSSE

Beckner, Thomas III, Memphis, TN, to 1505 Brentwood Dr, Greenville, TN 37743

MANITOWOC

Cassidy, George E, Manitowoc, to 9600 Gross Point Rd, Skokie, IL 60076

MILWAUKEE

Buan, Rolando R, Fox Point, to Rte 2, Tomah 54660

DeCock, David G, Wauwatosa, to Naval Regional Medical Center, 7500 East Carson St, Long Beach, CA 90822

Hogarty, Thomas J, Milwaukee, to 820 Dunnuck, Sheridan, WY 82801

Riddle, Patrick J, Gretna, LA, to 129 Eastmoor, Silver Springs, Md 20901

PRICE-TAYLOR

Borish, Jane, Park Falls, to 650 Fediker St, Parlier, CA 93648

PORTAGE

McGinnis, Kathleen J, Stevens Point, to Kongiganak, CPO Bethel, AK 99559

RACINE

G P Ferrazzano, Racine, to 1927 Belleair Rd, Clearwater, FL 33516

VERNON

Boehme, Larry R, Hillsboro, to 1516 Congress Ave, Saginaw, MI 48602

DEATHS

Sumner, Willare C, Rock County, July 15, 1978

Thomas, George L, Rock County, July 21, 1978 ■

OBITUARIES

◈County, State, AMA Members

◈ **Leo Thomas Schlenker, MD,** 55, Kenosha, died June 20, 1978 in Kenosha. Born Dec 5, 1922 in Kenosha, Doctor Schlenker graduated from Marquette University School of Medicine in 1947. He began his medical practice as an orthopedic surgeon in 1948 in Kenosha; and with the exception of serving two years in the United States Army from 1951-1953, he practiced in Kenosha until his retirement in 1978. Surviving are his widow, Betty; six sons, Dr Thomas, Milwaukee; Terry, Madison; and Timothy, Todd, Ted, and Toby of Kenosha; and four daughters, Mrs Darrel (Kathleen) Viola, Karolyn and Kimberly, all of Kenosha; and Kristine, Madison.

◈ **Paul Krueger Edwards, MD,** 81, Iron River, died June 23, 1978 in Duluth, Minn. Born Aug 1, 1897 in Beetown, Wis, Doctor Edwards graduated from the University of Wisconsin Medical School in 1929, and served in the United States Navy during World War I. He practiced medicine in Barron and Bloomington until he moved to Iron River in 1970. He retired from medical practice in 1976. Surviving is his widow, Ivanelle of Iron River.

◈ **Frank Urban, MD,** 82, Green Bay, died July 1, 1978 in Green Bay. Born Feb 18, 1896 in Metz, France, Doctor Urban graduated from the University of Illinois School of Medicine in 1945. Prior to receiving his medical degree, he was an assistant professor in chemistry at the Washington University School of Medicine in St Louis. He served as Green Bay health commissioner from 1956-1966. Surviving are his widow, Helen; and two sons, Dr Frank H of Elm Grove, and Dr James G of Denver, Colo.

◈ **Willard C Sumner, MD,** 80, Edgerton, died July 15, 1978 in Edgerton. Born Oct 6, 1897 in Fennimore, he graduated from Rush Medical College, Chicago, in 1927. Doctor Sumner practiced medicine in Edgerton from 1929 until his retirement in 1976. In 1977 he was granted a Life Membership to the State Medical Society of Wisconsin. Surviving are his widow, Marie; a daughter, Mrs Robert Mainz, Santa Barbara, Calif; and his mother, Mrs A E Sumner of Edgerton.

◈ **George L Thomas, MD,** 67, Janesville, died July 21, 1978 in Elkhorn. Born Dec 10, 1910 in Cumberland, Doctor Thomas graduated from the University of Wisconsin Medical School in 1936. He was a past president of Rock County Medical Society and the Milwaukee Orthopedic Society. Surviving are two sons, Dr Jeffrey, Janesville, and George of Lancaster, Pa. ■

"ALCOHOL AND YOUR UNBORN BABY": A NEW BROCHURE

The SMS Communications Dept and the SMS Committee on Maternal and Child Health announce the availability of "Alcohol and Your Unborn Baby," a new small-sized brochure warning women of the potential dangers alcohol can have on their unborn child. The brochures are perfect for placement in physician reception rooms or as statement stuffers. They are available free in any quantity from the SMS Communications Dept, PO Box 1109, Madison, Wis 53701. ■

TOXICOLOGY SEMINAR IN HAWAII
MARCH 9 - 17, 1979

a practical and applied approach to the management of poisoning emergencies for physicians, pharmacists, and other health professionals.

Presented by the College of Pharmacy, University of Minnesota, in cooperation with the National Poison Center Network. The faculty for the program includes . . . . .

RICHARD R MORIARITY, M.D., Director, National Poison Center Network; Associate Professor, Pediatrics, University of Pittsburgh.

WILLIAM O ROBERTSON, M.D., Director, Poison Center, Children's Orthopedic Hospital and Medical Center, Seattle; Professor, Pediatrics, University of Washington.

EDWARD P KRENZELOK, PHARM.D., Director, Hennepin Poison Center; Assistant Professor, College of Pharmacy, University of Minnesota.

ACPE The University of Minnesota College of Pharmacy is approved by the American Council on Pharmaceutical Education as a provider of continuing pharmaceutical education. Category I AMA credit applied for. Endorsed by the Minnesota chapter of APEC and by the Emergency Professional Physicians Association.

FOR FURTHER INFORMATION, CONTACT:

Thomas M. McKennell, Director, Continuing Education, College of Pharmacy, University of Minnesota, 128 Pleasant St. S.E., Minneapolis, MN 55455. (612) 376-5313.

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NEWS HIGHLIGHTS

New UW hospital

. . . will not have more beds than the present hospital, as rumored, according to the "movin'on" bulletin of the UW Center for Health Sciences in Madison. The new hospital will have a total of 556 beds, the same number as presently at University Hospitals. The new hospital—called University Hospital and Clinics—occupies slightly more than half the space in the Clinical Science Center. The rest of CSC space is occupied by the Nursing School, the clinical departments of the Medical School, and the Wisconsin Clinical Cancer Center. The new hospital is scheduled to move into CSC in March 1979. Most of the inpatient beds are on the 4th, 5th, and 6th floors of CSC. The 3rd floor contains operating rooms, the emergency room, the trauma and life-support center (TLC) and burn center. The 2nd floor houses many of the clinics.

Medical College of Wisconsin

. . . Class of 1982, which began its first day August 28, is the largest class in the history of the College. It's also unique in many ways. It will be the first class to begin training in the new Medical College of Wisconsin building on the Milwaukee County Institutions grounds. Of the 180 students enrolled, 135, or 75 percent, are from Wisconsin. There are 45 females and 15 minorities.

This also is the first class that includes students from the innovative premed Target MD program run in collaboration with the University of Wisconsin-Milwaukee. Seventeen students enrolled in the accelerated seven-year MD program have completed three years of premed training at UWM and now have four years of medical school at the Medical College.

Laboratory classes for first and second year medical students will be held in the departmental wing of the new building. Lecture series will be temporarily conducted in Coffey Auditorium at Milwaukee County Medical Complex until September 18 when the multi-use wing of the new building will be occupational.

Third and fourth year medical students who are training in their clinical years will rotate as usual through the College's major teaching hospitals. Classes for graduate students enrolled in the master's and doctoral programs in the basic sciences also began August 28.

There are a total of 600 medical students enrolled in the MD program and 100 full-time students enrolled in the graduate program.

A Seminar

. . . entitled "Physicians and Hospital Managers as Partners in Risk Management" will be presented by the American Hospital Association, October 6-7, at the Marriott O'Hare in Chicago. The seminar is designed to identify and attempt to solve the problems and issues that arise in obtaining physician involvement in hospital risk management programs. Further information may be obtained from Arline Sax at the AHA in Chicago: 312/645-9498.

Deaconess Hospital

. . . in Milwaukee has announced the appointment of John D Hurley, MD* as chief of surgery. Doctor Hurley will temporarily continue his duties as medical director of the Masonic Diagnostic and Treatment Center at the hospital, a post he has held since 1973. Stepping down as chief of surgery, Jack K Herrington, MD* said he will now devote full time to his clinical private practice. He has headed the department for nearly four years. Doctor Hurley, who has served as director of the Tumor Clinics at Milwaukee County General Hospital and St Mary's Hospital (Milwaukee), has been on the staff at Deaconess since 1963.

Medical College of Wisconsin

. . . has appointed two women to top administrative positions, Dean Edward J Lennon, MD* has announced. Coryce O Haavik, PhD has been appointed associate dean for graduate studies and Sally Y Long, PhD has been appointed assistant dean for student affairs. Doctor Haavik, an associate professor of pharmacology, replaces Donald Greiff, ScD, who has returned to full-time teaching and to his investigative work in cryobiology. An associate dean for graduate affairs, she will be responsible for graduates in the basic sciences. The new position of assistant dean for student affairs was created to meet the needs of the growing medical student body. Currently 600 students are enrolled in the medical degree program. Doctor Long will assist Paul Rosenfeld, MD, who has been promoted to senior associate dean and director of student affairs. ■

PHYSICIAN BRIEFS

Marion K Ledbetter, MD

. . . Neenah-Menasha, recently joined the medical staff of the Nicolet Clinic to practice pediatric cardiology. Doctor Ledbetter formerly practiced in Madison from 1968-78.

Joel L Furda, MD
Daniel Johnson, MD

. . . Rhinelander, recently became associated with the Bump Clinic and Forest Medical Center, Crandon. Doctor Furda graduated from the University of Iowa Medical College and served his internship and residency at Hennepin County Hospital, Minneapolis. Doctor Johnson graduated from the University of Minnesota and served his internship and residency at St Paul Ramsey Hospital and the Minneapolis Veterans Administration Hospital.

Charles Hansell, MD

. . . Columbus, recently opened his medical practice in the specialty of Family Practice. Doctor Hansell graduated from Indiana University School of Medicine and served his residency in Fort Wayne, Ind, where he also had a private practice. Prior to moving to Columbus, Doctor Hansell served in the United States Air Force for two years.

Steven D Driggers, MD
Gary A Schmidt, MD

. . . Manitowoc, recently became associated with the Family Practice Associates. Doctor Driggers graduated from the University of Illinois College of Medicine and served his family practice residency at the Methodist Medical Center of Illinois, Peoria School of Medicine. Doctor Schmidt graduated from the University of Wisconsin Medical School, Madison, and also took his family practice residency at the Methodist Medical Center of Illinois, Peoria School of Medicine.

Michael J DeBevec, MD

. . . Hayward, recently became associated with the Hayward Medical Group, S C. Doctor DeBevec attended the University of Minnesota Medical School, including a year of study and instruction in rural family practice in Grand Marais, Minn. He finished his residency at the St Francis-Mayo Family Practice in La Crosse.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: **Hypersensitivity:** Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. **Hepatic and Renal:** Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. **Other:** Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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John Oujiri, MD
David Saarinen, MD
Paul Van Pernis, MD
. . . Ashland, recently became associated with the medical staff of the Memorial Medical Center. The physicians have completed their family practice residency program at Saginaw, Mich. Doctor Oujiri is a 1975 graduate of the University of Iowa College of Medicine and Doctors Saarinen and Van Pernis are graduates from the University of Michigan Medical School and Rush Medical College. The addition of the three family practitioners brings the medical staff of MMC to 32, almost three times as many as when the hospital opened, less than six years ago.

R Buckland Thomas, MD
. . . Monroe, has joined the Department of Psychiatry of the Monroe Clinic. Doctor Thomas is a graduate of the University of Illinois College of Medicine. He served three years in the United States Army and after service went into private practice in Columbia, S C. While in South Carolina Doctor Thomas taught at Hall Psychiatric Institute, which is affiliated with the University of South Carolina. In 1972 he was on the teaching staff at Loyola University School of Medicine and was assistant chairman of the Department of Psychiatry until 1975 when he became the medical director at St Albans Private Psychiatric Hospital in Radford, Va.

Kenneth N Krutsch, MD
. . . Washburn, has become associated with Timothy A Kurten, MD*, Ashland, in the practice of urology. Doctor Krutsch graduated from the University of Wisconsin Medical School, Madison, and completed his urology residency at University Hospitals, Madison. He is on the medical staff of Memorial Medical Center in Ashland.

Thomas Schueppert, MD
Thomas Steed, MD
. . . recently became associated with the Door County Medical Center, Sturgeon Bay. Doctor Schueppert, a graduate of the Medical College of Wisconsin, is the first orthopedic surgeon to establish a medical practice in Door County. He served his internship and general surgery residency at the Gundersen Clinic in LaCrosse and completed his orthopedic training at St Francis Hospital, Peoria, Ill. Doctor Steed, a specialist in internal medicine, also is a graduate of the Medical College of Wisconsin. He served his residency at the Medical College of Wisconsin affiliated hospitals.

Thomas T Midthum, MD
. . . Baraboo, has begun his medical practice with Medical Associates, SC, Baraboo. He graduated from the University of Wisconsin Medical School, Madison, in 1975 and served his residency in Iowa City, Iowa.

Edward Cardona, MD
James B Gerstner, MD
Leah A Reimann, MD
. . . LaCrosse, recently became associated with the medical staff of the Gundersen Clinic Ltd. Doctor Cardona graduated from Stony Brook Medical School, Stony Brook, Long Island, and served his internship and residency at Indiana University Medical Center. Doctor Gerstner graduated from the University of Illinois College of Medicine, Chicago, completed his internship and residency at Lutheran Hospital, LaCrosse, and recently completed a hematology fellowship at Mayo Clinic, Rochester. Doctor Reimann graduated from the University of Wisconsin Medical School and served her internship at LaCrosse Lutheran Hospital and her residency in pediatrics at the Mayo Graduate School of Medicine in Rochester.

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William Fast, MD

. . . Boscobel, has become associated with MDs E M Randall,* J R McNamee* and C E Mueller* of the Boscobel Clinic. Doctor Fast graduated from the University of Minnesota Medical School and served his internship and residency at Fairview-St Mary's Hospital in Minneapolis.

Gerald H Clamon, MD
Charles R Nordstrom, MD
Steven D Stenzel, MD

. . . Eau Claire, have joined the medical staff of the Midelfort Clinic. Doctor Clamon received his medical degree from Washington University, St Louis, Mo, and is in the Department of Internal Medicine. Doctor Nordstrom graduated from St Louis University, St Louis, Mo, and completed his residency in internal medicine at St John's Mercy Medical Center in St Louis. Doctor Stenzel graduated from the University of Iowa Medical School and served his residency at Butterworth Hospital, Grand Rapids, Mich. He has joined the Department of Obstetrics and Gynecology.

Louis Kretchmar, MD*

. . . Milwaukee, is winding up 55 years of medical practice. Doctor Kretchmar has practiced in the Milwaukee area, except for a few months in Crandon, for the past 55 years. He graduated from the Marquette University School of Medicine and served his internship at St Joseph's Hospital. He was president of the Marquette Medical Alumni Association in 1952-53 and served as secretary of the Medical Society of Milwaukee County in 1946. He is a life member of the Milwaukee Academy of Medicine and also is a fellow of the American College of Surgeons. *(Milwaukee Journal Photo)* ■

DOCTOR KRETCHMAR

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1978

2 The Optometric Drug Bill, Promulgation of Rules
3 SMS School Health Committee
4 Ad Hoc Committee on Lab Certification of SMS Commission on Governmental Affairs
4 Executive Committee of SMS Council, Madison
5 SMS Council
5 SMS Committee on Economic Medicine
5 Finance Committee of SMS Council
8 WisPRO District Managers
8 WisPRO LRC Meeting
9 SMS Commission on Governmental Affairs
9 Ad Hoc Committee on State Health Insurance
10 SMS Commission on Peer Review
10 Health Care Coalition
14 SMS Work Week of Health Planning Committee
16 WisPRO Criteria Committee
17 Wisconsin Immunization Coordinating Committee
18 SMS Physicians Alliance Commission
18 SMS Medical Liability Committee
19 *Editorial Board of Wisconsin Medical Journal, Madison*
22 Resident Physician Section
22 Dane County Physicians Alliance Committee
23 WisPRO Advisory Group
24 WisPRO Review and Evaluation Committee
29 Cost Evaluation Committee
30 Wisconsin Review Foundation
31 WisPRO Review Coordinator Conference
31 WisPac

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS SEPTEMBER 1978

Green Bay in '78 and Madison in '79

THE PROFESSIONAL DEVELOPMENT and Advancement Seminars (PDAS) of the Wisconsin Society of the American Association of Medical Assistants (AAMA) will be held this coming year in two of the busiest cities this state has to offer.

November 4 in Green Bay at the Midway Motor Lodge and March 3 in Madison at a site yet to be named, medical assistants from all over the state will be gathering for a full day of learning. Continuing education units, or CEUs, will be applied for and offered at each. If the participant passes the quiz given at the end of each speaker's program, she will be awarded 0.1 CEU for each hour presented.

CEUs are proof that the participant has actually learned. The quizzes are made up by the speaker and corrected by members of the Education Committee. The passing score has to be 70% correct before a CEU can be awarded. Certified Medical Assistants (CMA) are most interested in getting CEUs for revalidation of their certification which is now required every five years. A total of 5 CEUs or 50 contact hours must be obtained in order to retain the status of being certified. If the CMA has passed a clinical, administrative, or pediatric specialty, another 2 CEUs must be achieved within that 5-year span as well.

Please encourage your medical assistant to attend. Topics she may be interested in include the following: Stress and Your Job, Federally Funded Insurance Programs, Microbiology and Urinary Tract Infections (Green Bay only), and Rheumatology (Madison only). These programs will take the entire day. For those with interest in certification, the mini-test, a preview of the basic examination will be offered by the Certification Committee at 7:00 AM for a fee of two dollars. Immediately following the mini-test a review will be held.

Registration fees cover all materials and lunch; flyers for registration will be mailed through the State Medical Society of Wisconsin in September and January. Registration fees are as follows: $10.00 for AAMA members and medical assistant students, $20.00 for nonmembers. We think one of your medical assistants could benefit from attending.

Accreditation for doctors is required annually; what better way then to keep in step with the ever-changing medical world than to attend a seminar! Opportunity to meet with your peers is always welcomed, and this chance will only come around twice this year. Last year 330 participants took advantage and attended the two PDASs; each was offered 5 hours of continuing education, for a grand total of 1,150 hours. If your medical assistant wasn't one of them, she missed out on medical law and ethics, workshops on diabetes and urinalysis, and communications.

Who are these participants? Members of the AAMA's 18 local chapters throughout the state, medical assistant students from the local technical schools and colleges, and members of physician's offices. Those axioms about teaching dogs new tricks and making waves do not belong in an efficient office where new laws and techniques are part of the everyday job. The medical office assistant needs new up to the minute information; these are two opportunities just for the purpose.

The AAMA-Wisconsin Society would like to meet more medical assistants and find out what subjects they would like to hear. Our six basic topics are:

1. Medical terminology, basic anatomy and physiology
2. Psychology, human relations, patient contact
3. Medical law, ethics, and economics
4. Administrative procedures and professional growth
5. Clinical procedures
6. Pediatrics

Sponsorship by the AAMA guarantees that the speakers and topics meet certain criteria in order for the CEUs to be approved; awarded CEUs means that the participant has passed a quiz at the end of the presentation and has obtained that knowledge.

If you need more information please contact Carol Norton, CMA-C, Chairman, 7103 Pershing Blvd, Kenosha, Wis 53142, or Linda Joy Stephens, Financial Chairman, 2026 St Clair Street, Racine, Wis 53402.

Will your medical assistant be in the audience November or March? We hope so; we have a lot for her to learn on those two days.

—CAROL NORTON, CMA-C
Education Chairman, PDAS ▪

WPS

report

for Wisconsin Physicians

Volume VII, Number 5

September 1978

HEALTH EDUCATION FILMS

Effective health education is often aided by visually interesting, dramatic expositions of the personal nature of health. WPS offers four films on signifigant preventive health issues to interested individuals, organizations and community groups. Each can be adapted to appropriate patient education activities.

You Can't Buy Health is a 27 minute, color, 16 mm film that selects a variety of health promoting activities -- such as fitness classes for the elderly, exercise trails and cardiac rehabilitation programs -- to demonstrate that people can take action to protect their health. In addition to emphasizing that lifestyle health habits can help protect an individual from illness, the film also points out the apparent cost savings for a nation that is healthy and more fit.

Smoking: How To Stop is a 26 minute, color, 16 mm film that follows the day-to-day difficulties of a young woman who is giving up smoking. Viewers can observe various behavior modification techniques and can better appreciate the importance of support and understanding from family members and friends in breaking this habit. This film is an appropriate introduction to a smoking cessation group.

The Other Guy is a two part, color, 16 mm film, each part running 27 minutes. The film depicts the life of an executive whose excessive social and business drinking leads to alcoholism. With help from family and health professionals, the executive follows the often difficult path to recovery.

Suicide: The Will To Die is a two part, color, 16 mm film, each part running 27 minutes. The film presents general information and statistics on suicide and the true case history of a woman who has had three unsuccessful suicide attempts.

The films are available for one-week loans. To order a film, write to the Communications Division, WPS, P.O. Box 8190, Madison, WI 53708. Indicate your first and second choices of dates for viewing the film. If there is a conflict in scheduling for those two weeks, WPS staff will contact you to arrange another date.

Please bring to your Medical Assistants' attention the portion of "Report" relevant to their work.

If you have any questions or comments on "Report," send them to WPS, Communication Division, 1717 West Broadway, Madison, WI 53713.

***Report** is a service to the physicians of Wisconsin.*

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and their Medical Assistants

Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) Claims

Occasionally, you must submit a CHAMPUS claim for a patient. Since the CHAMPUS claim form and procedures may be unfamiliar to you, we are offering you the following general guidelines:

1 The beneficiary, or the person receiving the medical service, completes Section I of the claim form, items 1 through 13. If you are assisting the individual in filling out Section I, be sure the correct effective date is copied from the CHAMPUS identification card and used in item 5. If the date is missing, or if the expiration date is used erroneously, payment may be delayed. Item 13 must be signed by the patient, or by the parent or guardian if the patient is under 18.

2 The physician providing the medical care completes the pertinent items in Section II. This requires supplying information on diagnosis, related hospitalization and specifics about the services provided. You may choose to have the beneficiary or the patient complete this part of the form; however, that individual will need a document that contains at least the following information: name and address of the physician, patient's name, date of care or service, amount charged, diagnosis or description of illness or injury, and name and dosage of drugs and injections dispensed or administered. Additional information may be needed depending on the services and the speciality of the physician. Without such complete information, either on a claim form or in an accompanying document, CHAMPUS regulations require that the claim be rejected.

3 If the physician **chooses to participate** CHAMPUS and accept CHAMPUS-determin reasonable cost charges as full payment f services and supplies, then the physician sig the claim form (Item 20). Appropria CHAMPUS payment will go directly to t physician. If the physician **chooses not participate** the claim form should not signed. In that case, discuss the method payment with the beneficiary or the patie who will receive the CHAMPUS payment.

4 Send the completed claim form, and a supporting documents, to WPS CHAMPU P.O. Box 7953, Madison, WI 53707. This b number is specifically designated for clai from non-hospital sources of care; Box 79 is used for general correspondence CHAMPUS matters. If the beneficiary patient chooses to send in the claim for your assistance in pointing out the prop address and box number will be great appreciated.

5 You may obtain additional copies of t CHAMPUS claim form by contacting W (Box 7927) or the CHAMPUS advisor at t nearest military base.

For more specific information on claims filir and other CHAMPUS matters, contact WPS b mail (Box 7927) or consult CHAMPUS Regul tion DOD 6010. 8-R.

CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 WISCONSIN

Oct 2-3: *Selected Problems in Pediatric Neurology,* Dept of Neurology, The Medical College of Wisconsin, Milwaukee Children's Hospital, Milwaukee. Info: Jennie M Evenson, tel: 414/931-4074.

Oct 12: Regional Cancer Conference, Pioneer Inn, Oshkosh.

Oct 13-14: Wisconsin Neurological Society, Marriott Inn, Brookfield, Wis. See details in box elsewhere in this section.

Oct 14: *Wisconsin Radiological Society,* The Concourse, Madison, Wis 53701

Oct 16: *Milwaukee Academy of Medicine,* University Club of Milwaukee, Milwaukee, Wis 53202

Oct 17: *Alcohol and Other Drug Abuse Among the Elderly,* a public conference in LaCrosse, sponsored by the Wisconsin Association on Alcoholism and Other Drug Abuse, Inc. Info: Don Johnson, WAAODA, 333 W Mifflin St, Madison, Wis 53703 (608/257-7970).

Oct 18: *Rheumatology Update,* CME course sponsored by Theda Clark Regional Medical Center, at Valley Inn, Neenah, in cooperation with Arthritis Foundation of Wisconsin and Merck, Sharp & Dohme Postgraduate Program. Seven hours Category I credit for PRA-AMA; 7 credit hours by AAFP. Registration: $12. Faculty: John Skosey, MD, Abraham Lincoln School of Medicine, Univ of Illinois, Chicago; William S Irvin, MD, Univ of Missouri, Columbia; and John H Grandone, MD, Nicolet Clinic, Neenah. Info: Paul B McAvoy, MD, Theda Clark Regional Medical Center, 130 Second St, Neenah, Wis 54956.

Oct 27-28: *Wisconsin Chapter, American College of Emergency Physicians,* Red Carpet Inn, Milwaukee, Wis 53202

Nov 2-3: *Alcoholism is a Woman's Issue,* a public conference in Madison, sponsored by the Wisconsin Association on Alcoholism and Other Drug Abuse, Inc. Info: Hilary Freeman, Women's Alliance Project of WAAODA, 333 W Mifflin St, Madison, Wis 53703 (608/257-7970).

Nov 3: *The Adolescent in Therapy,* at Hoffman House-Midway Motor Lodge, LaCrosse. Info: Gundersen Medical Foundation, Ltd, 1836 South Ave, LaCrosse, Wis 54601.

Nov 3: *Pediatric Emergencies,* Fall Pediatric Day, Wisconsin Chapter, *American Academy of Pediatrics,* Wisconsin Center, Madison, Wis 53706

Nov 15-17: Amipaque Myelography and New Techniques in Neuroradiology, UW-Madison. Fee: $190. Contact: Lyn Apfel, 465B WARF Bldg, 610 N Walnut St, Madison, Wis 53706. Category 1 approved.

Nov 18: *Wisconsin Dermatological Society,* Milwaukee County General Hospital, Milwaukee, Wis 53202

1978 NEIGHBORING

Oct 10-14: *Medical Knowledge Self-Assessment Program Course,* Ambassador West Hotel, Chicago, Ill. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, Pa

Oct 21-25: Annual Convention, Indiana State Medical Association, at Marriott Inn, Clarksville, Ind 47130

1978 OTHERS

Oct 6-8: Michigan Regional Meeting, American College of Physicians, Otsego Ski Club, Gaylord, Mich. Info: Boy Frame, 543 Lakepointe, Grosse Pointe Park, Mich 48230.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

Nov 14-17: Thirty-second World Medical Assembly, Manila, The Philippines. Info: World Medical Association Inc, 13 Chemin du Levant, 01210 Ferney-Voltaire, France. *Without delay.*

Dec 4-8: *Fluid and Electrolyte Balance, Hypertension and Renal Diseases,* American College of Physicians Postgraduate Course, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Ill. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

1978 AMA

Dec 2-6: House of Delegates Interim Meeting. Chicago.

Dec 7-10: Winter Scientific Meeting. Las Vegas.

1979 WISCONSIN

Jan 4-10: Medical College of Wisconsin annual postgraduate course in *Gynecological Pathology, Cytogenetics and Endocrinology,* at Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Feb 13-14: Wisconsin Chapter, American College of Emergency Physicians, Alpine Valley Resort, East Troy. Subject: Cold injuries—recreational and industrial.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835.

PRACTICAL MANAGEMENT OF STRESS RELATED PROBLEMS—I

Sponsored by AMERICAN HOLISTIC MEDICAL ASSOCIATION

Co-sponsored by the American Society of Contemporary Medicine and Surgery and Biogenic Institutes of America, Inc.

Oct 13-14, 1978
Capitol Hilton, Washington, DC

As an organization accredited for continuing medical education, The American Society of Contemporary Medicine and Surgery certifies that this continuing medical education activity meets the criteria for 11 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

Info: Contact AHMA, Rt #2, Welsh Coulee, LaCrosse, Wis 54601 Tel: 608/786-0611 p9/78

1979 NEIGHBORING

Mar 5-8: *Neurology for the Internist,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Mar 7-9: Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists, Conrad Hilton Hotel, Chicago.

63rd ANNUAL USA-CANADA SCIENTIFIC ASSEMBLY INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA

Oct 23-26, 1978

Washington Hilton
Washington, DC

Program

Monday am: *Rheumatology*

Monday pm: *Gastrointestinal*

Tuesday am: *Pediatrics*

Tuesday pm: *Infectious Diseases—Bacterial and Viral*

Wednesday am: *Cardiology*

Wednesday pm: *Hypertension*

Wednesday Evening—Annual Banquet

Thursday am: *Update on Current Trends and Technology*

This conference will assist Family Physicians, Generalists and other interested physicians in updating their clinical knowledge in the diagnosis and treatment of the commonly occurring problems in Rheumatology, Dermatology, Pediatrics, Cardiology, Hypertension, Gastrointestinal, and Infectious Diseases.

Program acceptable by the College of Family Physicians of Canada and the American Academy of Family Physicians for 24 hours of prescribed credit and 4 hours of elective credit if movies are viewed.

Also 24 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association and 4 hours of Category V credit if movies are viewed.

Info: Postgraduate Medical Association, PO Box 1109, Madison, Wisconsin 53701.

May 16-18: *Cardiac Auscultation and Cardiac Examination,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St, Philadelphia, Pa 19104.

1979 OTHERS

Apr 4-6: National Conference on High Blood Pressure Control, The Washington Hilton, Washington, DC. Sponsored by the National High Blood Pressure Education Program Coordinating Committee. Info: Conference Headquarters, NCHBPC, 1501 Wilson Blvd, Suite 600, Arlington, Va 22209; tel 703/527-4500. g9/78-2/79

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

WHAT'S NEW IN EMERGENCY MEDICINE

also featuring cost-containment measures

presented by

Wisconsin Chapter, American College of Emergency Physicians

Friday-Saturday/October 27-28
Red Carpet Inn, Milwaukee

Guest speaker:
Donald Kunkel, MD, JD
Phoenix, Arizona

Program followed by Annual Meeting and Election of Officers

Further info: C Randolph Turner, MD, President, 7335 Maple Terrace, Milwaukee, Wis 53213.

FALL REGIONAL CANCER CONFERENCE

Thursday, October 12 • Pioneer Inn, Oshkosh

am		
7:30	Registration	
8:00	Welcome—*Paul P Carbone, MD*	
8:05	Reliable Screens—*Richard R Love, MD*	
8:35	Mammography—*Raul H Matallana, MD*	
9:05	Nuclear Medicine—*Robert E Polcyn, MD*	
9:35	CT Scanner—*George Wirtanen, MD*	
10:05-11:05	Breast Workshop Group A *Alvin J Greenberg, MD* Chairperson *Robert O Johnson, MD* *Raul H Matallana, MD* *Douglass Tormey, MD*	Lung Workshop Group B *John R Pellett, MD* Chairperson *Ernest C Borden, MD* *Joyce C Kline, MD*
11:20-12:10	Repeat Workshop Group B	Repeat Workshop Group A
pm		
12:30	Luncheon—*John R Milbrath, M.D.*	
2:00-3:10	Gastrointestinal Workshop Group A *William H Wolberg, MD* Chairperson *Hugh L Davis, MD* *Albert L Wiley, MD*	Gynecology Workshop Group B *Dolores A Buchler, MD* Chairperson *Thomas E Davis, MD* *Mojmir G Sonek, MD*
3:10-4:20	Repeat Workshop Group B	Repeat Workshop Group A

Acceptable for 6 credit hours of Category I of AMA-PRA.

INFO: Registration deadline, Oct 2, 1978: $10.00 per person. Make check out to Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705.

Twenty First Meeting of Wisconsin Neurological Society
Marriott Inn
Brookfield, Wisconsin

Oct 13-14, 1978

Program: Oct 13, 1978

8:00-10:00 pm, Friday

R Clarke Danforth, MD will preside over the usual, informal and educational program aimed at the elucidation of various clinical and laboratory problems.

Program: Oct 14, 1978, Saturday

9:00 am—The Action of Inhibitory Amino Acids on Acute Models of Epilepsy, *Ruggero G Fariello, MD*, Madison

9:20 am—Epilepsy Due to Brain Tumors: A Clinical and Laboratory Study, *Francis M Forster, MD*, Madison

9:40 am—Single Fiber Electromyography. A New Dimension in the Electrophysiologic Evaluation of the Motor Unit, *James W Albers, MD, PhD*, Milwaukee

10:00 am—Coffee Break

10:20 am—To be announced

10:45 am—Is Volitional Manipulation of Hemodynamics a Valid Rationale for Biofeedback in Migraine? *Donald J Dalessio, MD*, Chairman Dept of Medicine, Scripps Clinical Medical Group, La Jolla, Calif.

12:00 pm—Lunch

SYMPOSIUM ON UNUSUAL NEUROLOGIC ENTITIES

1:20 pm—Eale's Disease with Neurological Involvement, *Bhupendra O Khatri, MD* and *E J Bravo-Fernandez, MD*, Milwaukee

1:40 pm—Trichinosis: Case Report and Discussion, *John L Bender, MD*, Rockford, Ill and *Dong C Hugh, MD*, Woodstock, Ill

2:10 pm—Neurologic Manifestations of Behcet's Syndrome, *Varun K Saxena, MD* and *James W Albers, MD, PhD*, Milwaukee

2:30 pm—Coffee Break

3:00 pm—Hyperthyroidism in Parkinson Disease, *William W Orrison, MD* and *Henry A Peters, MD*, Madison

3:20 pm—To be announced

4:00 pm—Business Meeting

Approved for Category I credit.

Info: Contact Francis M Forster, MD, Dept of Neurology, University Hospitals, 1300 University Ave, Madison 53706.

SECOND ANNUAL JOHN R SEBALD MEMORIAL HAND SYMPOSIUM

Seminar for primary care physicians, surgeons, nurses, occupational and physical therapists

Oct 13—St Paul, Minn
O'Shaughnessey Education Center, College of St Thomas

Featured speakers are:

- **Dr Harold E Kleinert**
  Clinical Prof of Surgery
  University of Louisville
  Louisville, Ky
- **Dr Robert W Beaseley**
  New York University
  New York, NY
- **Dr Robert D Beckenbaugh**
  Mayo Clinic
  Rochester, Minn
- **Barbara Johnson, OT**
  Mayo Clinic
  Rochester, Minn
- **Arnold Hamel, MD**
  Chief of Hand Service
  Hennepin County Medical Center

Application has been made for Category I credits, AMA, AAFP and Minnesota Nurses Association.

Included in this year's program is a workshop for Occupational and Physical Therapists.

Info: Administration, Bethesda Lutheran Medical Center, 559 Capitol Blvd, St Paul, Minn 55103. Tel: 612/221-2395. 9/78

NATIONAL MEDICAL SPECIALTY SOCIETIES

1978 Meeting Dates/Sites

Oct 23-26: Sixty-third Annual USA-CANADA Scientific Assembly, Interstate Postgraduate Medical Association of North America, Washington Hilton, Washington, DC. See details in box elsewhere in this section.

Oct 29-Nov 2: Forty-fourth Annual Scientific Assembly of the American College of Chest Physicians, Washington Hilton, Washington, DC.

Oct 16-20: Clinical Congress, American College of Surgeons, San Francisco.

1979 Meeting Dates/Sites

Jan 27-31: 35th Annual Congress, American College of Allergists, San Francisco, Calif.

Apr 26-29: Annual Meeting, American Society of Internal Medicine, New Orleans, La.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

CONTRIBUTIONS—CES FOUNDATION JULY 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1978.

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Medical Associates-Menomonee Falls; CB Moen, MD; Robert F Purtell, Jr, MD; Baldwin Clinic; Wisconsin Rural Rehabilitation Corp; Wisconsin Physicians Service—*Medical Student Summer Externship Program*
Membership Dues—*Aesculapian Society*

Memorials

Earl R Thayer; Marcella Herfel; Joan Pyre; Mavis Minor; LeRoy A Johnson—*Marvin Luther*
Dee Miller—*Marvin Luther (Student Loan Fund)*
Dr-Mrs Robert T Schmidt—*Lucille Daoust (Brown County Loan Fund)*
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EJ Nordby, MD—*George Thomas, MD*
Earl R Thayer—*Mother of Dr Timothy Flaherty*

MARK YOUR CALENDAR FOR FAMILY PHYSICIAN SEMINARS

Physicians still have time to register for the "One Day Seminars for Family Physicians" in Green Bay this fall. The seminars, sponsored again this year by the SMS Commission on Continuing Medical Education, are scheduled for Wednesday, October 18, at St Vincent Hospital and Wednesday, November 15, at Bellin Memorial Hospital in Green Bay. Each seminar qualifies for four hours of credit in Category I of the Physician's Recognition Award of the American Medical Association.

MORE ON FRIVOLOUS MEDICAL MALPRACTICE SUITS

Does the frivolous suit statute apply to medical malpractice cases begun before the law became effective? . . . No. Even though the author of the legislation, Representative Tom Hanson (D-Beaver Dam), stated that legislative intent was to make the statute as broad as possible, it would be difficult to apply the new law (effective April 7, 1978) retrospectively. Since the statute refers to "An action or special proceeding," Rep Hanson said this legislation would apply to the pretrial screening panels, as well as to court actions. If you would like a copy of this legislation or more information, call the SMS Physicians Alliance Division, toll-free 1-800-362-9080, extension 135.

NATIONAL SURVEY ON MEDICAL CARE EXPENDITURES UNDERWAY

Physicians may be contacted soon to provide information about their patients' utilization of health services, expenses, and methods of payment. HEW has contracted with three research firms (Research Triangle Institute, the National Opinion Research Center, and ABT Associates, Inc) to conduct the National Medical Care Expenditure Survey. About 30,000 physicians nationwide may be polled. Data from the survey will be used to prepare federal statistical summaries. According to HEW, most of the information has already been culled from about 12,000 households. Medical providers and hospitals delivering care to the households will be or have been contacted to provide utilization and financial information. Physicians who are contacted and who have questions about the survey may call a survey coordinator toll-free at: 1-800-225-1970.

PHYSICIANS: YOUR HELP IS NEEDED IN 'SMOKEOUT' CAMPAIGN

The State Medical Society and its Commission on Public Information recently endorsed the Great American Smokeout, a national effort to quit smoking for one day, November 16. The Great American Smokeout is being sponsored by the American Cancer Society in the hope that if people see that they can successfully quit smoking for one day, perhaps they will try to quit for good. Smokers are asked to sign pledge cards that they will not smoke on November 16, 1978. The card serves as a reminder of their commitment. Physicians are asked to promote this campaign in their offices. To obtain pledge cards, posters, or other items for distribution in your office, contact your local American Cancer Society chapter, or contact the American Cancer Society/Wisconsin Division office at 611 North Sherman Ave, Madison, Wis 53704; phone: (608) 249-0487.

BOOKLET ON T-19 PROGRAM OFFERED TO PHYSICIANS

"Getting Help for Health Care Problems," an informational booklet which answers many of the questions commonly asked concerning the Wisconsin Medical Assistance Program now is available to physicians on request. Physicians may obtain a copy of the booklet—free—by writing the Bureau of Health Care Financing, Room 325, Department of Health and Social Services, 1 West Wilson, Madison, Wis 53702. ■

WISCONSIN PHYSICIAN PLANNING NETWORK LAUNCHED

The SMS Commission on Health Planning September 21 gave the go-ahead to establish the "Wisconsin Physicians Planning Network" (WPPN), an SMS mechanism for organizing physician participation in the health planning process. Designed in response to the growth of health planning agencies in recent years, the WPPN will create Physician Task Forces (PTF) in each Health Services Area to provide medicine's views to local health planning activities. Recent experience with the development of the 1978 State Health Plan has demonstrated the need for organized, ongoing physician participation in the health planning process. WPPN is seen as a method for physicians and health planners to collaborate in producing a health planning program that contributes to the improved delivery of quality health services instead of burdensome policies and regulations. The organization of WPPN now begins. The SMS Quality Care Division is preparing an audio-visual presentation for county medical societies, hospital medical staffs, and other physician groups on the structure of the Wisconsin Physicians Planning Network and how physicians can become actively involved in the health planning process in Wisconsin. Any physician requesting more information on WPPN should contact Neal Neuberger at the SMS Quality Care Division at 1-800-362-9080.

EDS MEDICAID UNIFORM CLAIM FORM NOT UNIFORM!

Despite difficult but apparently successful negotiations with EDS-Federal, WPS, Surgical Care and other carriers to devise a uniform claim form for Wisconsin, EDS will issue a two-part, continuous computer claim form which is *not* the approved SMS/Clinic Managers form even though it carries that imprint. EDS has printed about 500,000 of the forms and plans to distribute them soon. Physicians' offices are warned that the EDS green form spacing is different from the approved uniform claim form endorsed by SMS and will pose problems for those who use computers. EDS has promised not to reissue the nonstandard form. Meanwhile, the SMS/Clinic Managers approved uniform health insurance claim form for Wisconsin is now being printed and will be available for use by December 1. Order forms are being sent to physicians now. This form will be *required* by EDS as of January 1, 1979 for *Medicaid;* it will be acceptable for *Medicare* and regular insurance by WPS, Surgical Care, and other insurance carriers. *Exceptions:* The Federal government CHAMPUS program.

SMS PRESIDENT RESPONDS TO JOURNAL ARTICLE

SMS President Jules D Levin, MD, Milwaukee, this month sent a letter to *Milwaukee Journal* Editor Richard Leonard in response to a September 24 story the *Journal* ran stating that medical bills were a significant factor in one out of every four bankruptcies filed in Milwaukee. In his letter Doctor Levin said that the article illustrates "very dramatically the reason why there should be a state-operated health insurance "pool" for individuals or families who are unable to buy health insurance because they are unemployed or have major health problems." He stated that the State Medical Society first proposed this in 1972, and AB 196 attempted to set up such a pool last year but unfortunately it "died" in committee. The State Health Policy Council also now supports this idea. "The Society urges physicians to discuss charges with patients," Doctor Levin wrote, "and that those families who need a financial 'break' be given special consideration." It is important that persons be willing to discuss these matters with the doctor or his office manager since there is usually a reasonable way to work out payment arrangements, including a reduction of fee or outright forgiveness of the bill, he said. Doctor Levin said that the State Medical Society is willing to assist in bringing a problem to a physician's attention if for some reason a patient feels unable to get the proper discussion with the doctor. ■

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WISCONSIN MEDICAL JOURNAL
1903 - 1978 75th ANNIVERSARY YEAR

USPS 688-360
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SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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WISCONSIN MEDICAL JOURNAL is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Opinion Page

At a recent meeting of the Editorial Board of the *Wisconsin Medical Journal* the concept of an opinion page was proposed. This could well be used as a sounding board for opinions of members of the Society and certainly not be limited to the Editorial Board or the Editorial Associates. Indeed, it was felt that some of the offerings that have appeared under the heading of editorials could be more accurately called opinions of the author. Some editorials have been withheld because they were simply too controversial or have been contrary to policies of the Council or the Society. These could be published as opinions, however.

If there are sufficient contributions to justify a periodic OPINION PAGE, it could become a very lively and widely read feature of the *Journal*. The first one starts in this issue.—VSF

The meaning of HSA

A FEW MONTHS AGO it was stated here that a surprising number of our members were not clear as to the meaning of the letters HSA. It was concluded then that those members were sadly uninformed, but perhaps their lack of knowledge reflects the fact that they may be practicing in an area where the Health Systems Agency (HSA) hasn't yet begun to feel its oats. As a result the HSA hasn't had much impact on their professional lives.

This is not the case in Southeastern Wisconsin where the HSA has not hesitated to take unpopular positions and attempted to make them stick. For example, it has refused to authorize services which had been initiated without the HSA's approval, has on occasion recommended mergers of competing institutions, and has even urged closure of under-utilized services in highly respected hospitals with good records of patient service over serveral generations. Of course, all this has been done in the interest ostensibly of saving community dollars.

That's all for the greater good you say—there are too many hospital beds in Southeastern Wisconsin anyway, and why should the rest of the state worry about the Milwaukee area?

Consider this: The Southeastern Wisconsin HSA has the advantage of operating in an arena served by two major daily newspapers and uses these media to get its message across to the public—sometimes deliberately prematurely if the HSA perceives it to be advantageous to do so.

Not long ago SEWHSA concluded that an obstetrical service in Milwaukee should be closed due to falling volume. The following morning the story appeared in the newspaper, even before the Board of Directors of the SEWHSA had approved the recommendation. The fact that the case is far from settled at this stage of a recommended closure is not what sticks in the public's mind. What the public remembers is that an obstetrical service in which it formerly had confidence must now have something the matter with it. The nurses, the aides, and other employees of that service begin to worry about their jobs, women awaiting delivery begin to have second thoughts, and the numbers shrink even more.

Actually there is no real evidence that shutting down a service will culminate in any saving of community funds. It may well do the reverse if the victim hospital is well run and if jobs are lost because of closure. Premature announcements which tend to misinform or prejudice the public do little to enhance the image of an HSA or earn the cooperation of the area physician, and may imply a more sinister meaning to the letters HSA than simply: Health Systems Agency.
—WJB

Comments On Treatment—A requiem

FOR FORTY YEARS a feature entitled "Comments on Treatment" has appeared fairly regularly in the *Wisconsin Medical Journal*. The original co-editors were the chairmen of the Departments of Pharmacology in the two medical schools in the state. These were Doctor Tatum at Madison and Doctor Beckman at Marquette.

In recent years there have been increasing problems in maintaining the continuity of this feature. Originally these were brief, usually one page, discussions of a single medication or treatment. Pharmacology, like every other aspect of medicine has become increasingly complex. From a handful of "specifics," pharmacology

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has burgeoned and no longer lends itself to brief comments on treatment.

Consequently, the Editorial Board, at its last meeting sadly terminated an old friend. The last one appears in this issue.—VSF

Doctor Garrett Cooper

In 1973 six members of the Editorial Board of the *Wisconsin Medical Journal* were recognized by the State Medical Society for their one hundred years of service. Since that time, two of the old guard have resigned and now a third, Doctor Garrett Cooper, has submitted his resignation.

Doctor Cooper, who is an Emeritus Professor of Dermatology at the University of Wisconsin Medical School, as well as having been in private practice in Madison and also a former member of the State Board of Health, has served on the Editorial Board for twenty-five years. The Society and the staff of the *Journal* are deeply grateful for this quarter century of dedicated service. His astute comments and searching questions are going to be sorely missed.

Doctor Cooper has graciously consented to act as a consultant to the *Journal* in manuscripts or problems relevant to his specialty—VSF. ■

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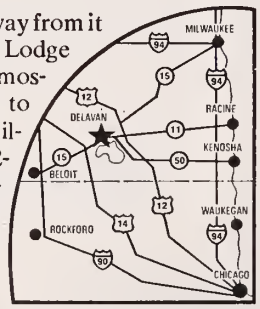

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Opinion/Dialogue

State Health Plan not cast in stone

I WANT TO EXPRESS my concern with the June *Wisconsin Medical Journal* editorial which characterized the 1978 Wisconsin State Health Plan as a "blueprint for socialism."

While it is true that the original plan had little physician input, many practicing physicians from throughout the state are now involved in the process of developing the State Health Plan and will continue to have an unusual opportunity to learn about the value of long-range planning. Planning is necessary; and when it is done in a reasonable way with sufficient physician input, it will help assure the availability of quality medical services at reasonable cost.

We must realize, however, that the Plan's goals, objectives, and recommendations are not cast in stone. Efforts are already underway to revise the 1978 Plan. The process is dynamic, and planning policies are constantly reevaluated to assure their appropriateness. The author of the editorial is partially correct when he states that the rates and availability of medical services will be determined by planners. But what he fails to realize is that often providers *are* the planners.

Our State Medical Society Commission on Health Planning has been reconstituted so that it can effectively coordinate the participation of physicians in the planning process and can have an impact on the policies and objectives of the State Health Plan. Our goal is to outplan the planners and I think we can do it.

We are beginning to develop a reasonable working relationship with the Health Policy Council and its staff. As they ask for more medical input, we need to involve more physicians in the planning process. Unfairly labeling the State Health Plan as a "blueprint for socialism" serves only to generate physician skepticism with a process that demands their meaningful participation.

I am optimistic that the health planning process, as it is developing, will be a meaningful and necessary one for health professionals and consumers. The State Medical Society Health Planning Commission intends to cooperate and support the planning process in every way.

MARVIN G PARKER, MD, *Chairman*
Commission on Health Planning
Racine

Conflict of interest

THE DOCTOR IS surrounded by conflict of interest. Examples abound, but most common are those related to filling out insurance forms. Most of us perform poorly in writing letters to insurance companies. We forget that our patient has a contract with the insurance company which specifies the circumstances under which health care costs will be reimbursed, and that our role is simply to describe or clarify the circumstances of the illness for which reimbursement is being sought. This rarely involves judgmental decisions and requires usually only a description of the chronology and facts of the case. Distortion of this material under pressure from the patient or by the physician's interest in the patient's well being is a common result of physician conflict of interest which is not becoming to the medical profession. We must all remember that each deviation from fact whether in dealing with patients, fellow providers, or third-party payors weakens the already tenuous credibility of the medical profession and that the short-term gains for an individual patient are not an appropriate tradeoff for our reputations.

NICHOLAS L OWEN, MD
Milwaukee

EDITOR'S NOTE: Doctor Owen, a practicing internist, functions also as a medical advisor to Blue Cross, and in that capacity is often called upon to review hospital charts which at times differ considerably in content from the information submitted by the patient and physician. ■

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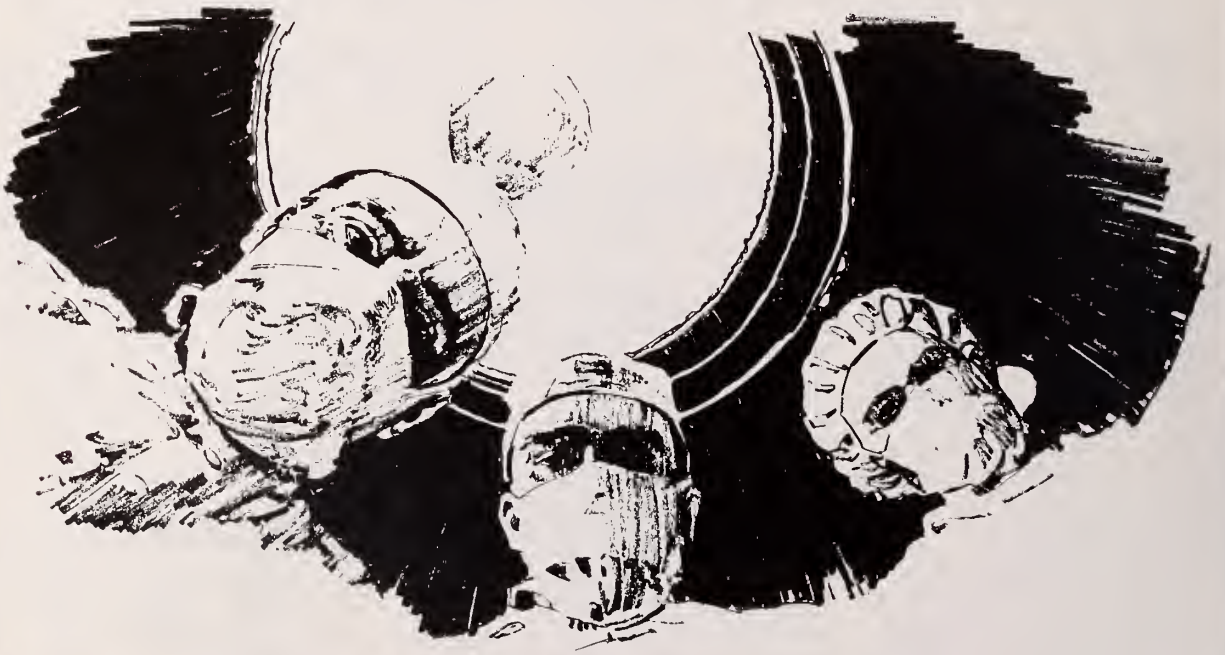

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Health & Planning Delivery

PART II: Interview with Dr John Peters

by JON SOFFER

THIS IS THE SECOND of a two-part special report analyzing the 1978 Wisconsin State Health Plan. The following interview is a followup to the August issue's interview with Health Policy Council Chairman Dr Ben Lawton.

This report focuses on a family physician from Fond du Lac, Dr John U Peters. Doctor Peters is a member of the Health Policy Council, the SMS Commission on Health Planning, and has been involved in several studies concerning health manpower.

Doctor Peters was interviewed in his Fond du Lac office by Jon Soffer, a medical journalism student intern with the *Wisconsin Medical Journal.*

Q. Doctor Peters, what is your assessment of the current health status of Wisconsin residents?

A. I think it's pretty good, but I really have no way of evaluating the quality of care delivered by all providers.

There are many things that disturb me about the overall quality of the Wisconsin health-care system. In this state there are people who don't have access to health insurance. This must be dealt with by providing insurance to the uninsurables and for those who incur a catastrophic illness.

In addition to the federally funded PSRO program, we should instigate a private review mechanism to cover those health-care areas that do not fall under government programs and one that will also provide an ambulatory peer review mechanism.

Q. Do you think the State should share the costs of public health services?

A. There should be a basic minimum of public health-care services funded by the State. Whether these are provided by the State or private sector should be determined by a joint committee of providers and the State. Unless such a committee is established, state services may duplicate what's already being done by the private sector and as a result you get a duplication and fragmentation of health care that is ultimately more costly.

The State Health Plan included recommendations which are referred to the DHSS. This could lead to an increase in the bureaucracy that few people want. Many of those recommendations could and should have been directed to the private health-care sector.

Q. According to Public Law 93-641 (the federal law governing the State Health Plan), the Plan should be composed of input from the State's seven health systems agencies (HSAs). Do these locally based agencies actually have a substantial input into state health policy?

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There should be a basic minimum of public health-care services funded by the State. Whether these are provided by the State or private sector should be determined by a joint committee of providers and the State.

A. Well, they don't right now. They do have some input, but the problem with the local HSAs is that their survival depends upon money. The only way they can obtain money is from certain grants that come from the federal government. A lot of the HSAs' time is spent on grants that really aren't pertinent to their particular area. The question with the HSAs is whether they really have the resources to do the type of planning that's needed for their area. Originally the planning law was intended to stimulate grass roots planning, and a lot of that is being done. But a lot is still being done at HEW in Washington — coming from the top down rather than from the bottom up — and that's not what the planning law intended!

Q. Do physicians have a sufficient voice in the Plan?

A. Yes, they do in our HSA area. Our group of physicians in the HSA area meets once a month to discuss health planning. We periodically invite the director of the local health systems agency to sit in on these meetings.

Q. Do you think it's possible for the State Health Plan to achieve its goal of "widespread, adequate, and inexpensive health care?"

A. I'm not sure what is meant by inexpensive care; however, the State Health Plan can achieve a goal of providing essential and quality care. Essential care is providing what is basically needed, and it would seem to me that essential and quality care at a reasonable cost to all Wisconsin citizens is a realistic goal.

Q. This is a quote taken from the introductory paragraphs in the Plan: "For medical services no one has been able to show a necessary connection between their availability in a community and that community's health status." Any comments?

A. I think good logic tells us that if services are available, health status will improve. If we don't accept that, we should pack our bags and go home.

Q. What do you see as the principal short-term and long-range benefits and disadvantages of the Plan?

A. I'm not sure where you make the demarcation between short and long term advantages. One advantage is that at least we have a planning format on which to build — at least we have a start for a State Health Plan. There are deficiencies within the Plan, and these create the need for a better State Health Plan. This foundation offers an avenue for a better planning mechanism. A disadvantage of the Plan is that it does not take into consideration the fiscal implications of its recommendations. The Plan has no provision for determining how much money will be needed to enact many of the recommendations. There needs to be a much better coordination between recommendations and their fiscal implications, thus providing a realistic State Health Plan based upon what the State can afford.

The question with the HSAs is whether they really have the resources to do the type of planning that's needed for their area.

Q. Do you think the Certificate-of-Need program will substantially cut health-care expenditures?

A. I would hope so. Based upon what I've been told, curtailing the number of hospital beds will save health-care costs. If you have multiple CAT scanners, you'll have multiple utilization of them. At times physicians have a tendency to prescribe diagnostic tests without looking at the budgetary impact of their decisions.

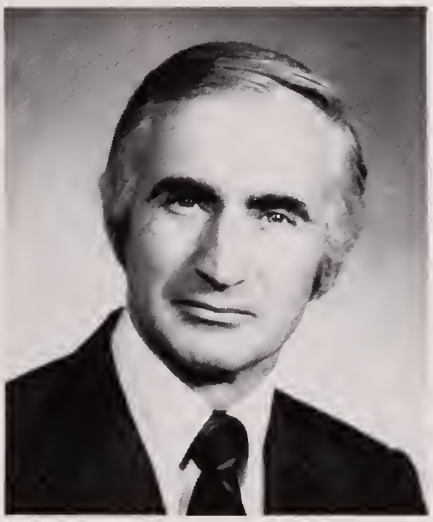
Q. Doesn't the State Health Plan fall short of its goals due to recurring vagueness in its recommendations and resource allocations?

A. In many areas the Plan falls short, but it is a start which needs to be built upon, particularly in manpower. We need a manpower plan that is much more specific than what's in the State Health Plan. In order to do that we first have to determine what services we can afford to provide the people of our State and make sure everyone, including the uninsurables, is entitled to those services. The second step we have to take is to determine who is going to provide those services. What sort of delivery models are we going to establish in the State that will provide those services. We shouldn't have a public health model duplicating a private practice model providing similar services. Planners have to spell out what type of health-care model will deliver health-care services in the State and stick with it. Having the personnel committee recommending variable models is impractical for health personnel planning. We need specific models. All models should have medical services in which a physician provides the medical care. The model also should have a provider who emphasizes health education and the preventative aspects of health care. We provide good medical care, but I question whether we do a good job of providing health care — that takes a team approach. If we use the joint practice or team approach, we can try to determine how many physicians the State's going to need and do something about assuring that we have the type of physicians who fit into that model. In addition we must determine how many nurse clinicians we are going to need. There's no sense in having 400 medical graduates a year in the State when, based upon what we know, we need only 250 physicians. That's not even per year, that's just what we need today.

I think good logic tells us that if services are available, health status will improve. If we don't accept that, we should pack our bags and go home.

Q. Should nurse clinicians be under the supervision of physicians?

A. They should be in joint practice with physicians. If they're in joint practice with a physician, the physician and nurse contribute to each other's knowledge and the patient benefits. I envision their roles as complementary, one not really having any supervision over the other. There is a very definite need for health edu-



John U Peters, MD . . . *a family practitioner with Associated Physicians in Fond du Lac. Since beginning his Fond du Lac practice in 1963, Doctor Peters has been active in a number of professional and governmental organizations. A member of the State Medical Society's Council, Doctor Peters also serves on the SMS's Commission on Health Planning and as the Family Practice representative to the Commission on Governmental Affairs. He has served various committees as a member of the Wisconsin and the American Academy of Family Physicians and is a delegate to the AAFP. He was active in the Great Plains and Wisconsin perinatal associations, and has served in an advisory capacity to nursing groups. As a member of the State Health Policy Council, Doctor Peters has focused on manpower, primary health care, licensure, health maintenance organizations, malpractice, maternal and child health care, health resources, and the legislative issues.*

There is a very definite need for health education and an increased emphasis on preventative medicine, and that's where I feel nurses can fill a void in the present health-care system.

cation and an increased emphasis on preventative medicine, and that's where I feel nurses can fill a void in the present health-care system. I don't think nurses should be practicing medicine. I know there's a philosophy in the State that the health-care providers should be able to expand their roles and that there shouldn't be any limitations or barriers in the expansion. I disagree. Nurses aren't able to compete with physicians when it comes to practicing medicine because they haven't had the medical training.

Q. One of the goals of the Plan is a 20% increase in ambulatory surgery. Isn't the place of surgery more appropriately decided by patients' needs than by an arbitrary percentage plan of an agency?

A. I would agree with the idea that of all the surgery being done, 20% could be done on an ambulatory basis. There should be encouragement of all physicians who are practicing surgery to use ambulatory facilities whenever feasible.

Q. The State Health Plan has been criticized for its unfamiliarity with specific medical services and for "editorializing" on health issues and policies. Any comments?

A. The people who drew up the Plan initially did not have that much medical experience and did not understand all of the ramifications of the recommendations they were making. They were trying to put together a State Health Plan, and there were public hearings on that. Everyone had an opportunity to have input into the State Health Plan and to modify those particular recommendations. The criticism you quoted from the State Medical Society is probably legitimate criticism, but at least the Health Plan is a start. A lot of input has come from the State Medical Society in hopes of modifying many of the recommendations. The Society would not have undertaken development of a State Health Plan on its own — somebody else had to. If the State Medical Society would have drawn up the Plan, there would have been certain inherent weaknesses in that plan because it would have omitted areas with which they were not familiar.

A disadvantage of the Plan is that it does not take into consideration the fiscal implications of its recommendations.

Q. In the final section of the Plan, there is a goal to strengthen the Health Policy Council's (HPC) role in state health policy. Do you have any closing comments on the future of the HPC?

A. The HPC, although its title is Health Policy Council, simply recommends policy to the Legislature. The HPC has to establish some sort of credibility with the Legislature because health policy in the State is really determined by the State Legislature. We can recommend policy to the legislative branch, the Governor, and the administrative agencies; and all of these have the ability to put our recommendations into policy. The weakness of the HPC, in the past, was its inability to have planning put into policy. We would make a recommendation to the Legislature that didn't go far simply because we were not a political body.

The HPC has to establish some sort of credibility with the Legislature because health policy in the State is really determined by the State Legislature.

The JOURNAL encourages replies or comments from interested readers. ■

CANCER COLUMN

PREPARED AND SUPPORTED BY

WISCONSIN CLINICAL CANCER CENTER

IN COLLABORATION WITH

STATE MEDICAL SOCIETY OF WISCONSIN

AND ITS

COMMITTEE ON CANCER

Primary and secondary prevention in cancer of the colon and rectum

TWENTY-FIVE HUNDRED Wisconsin residents will be discovered to have colo-rectal cancer in 1978.[1] Incidence of this malignancy in Wisconsin is among the highest in the nation, and the United States has one of the highest incidences in the world. At current rates, 1 in 25 Americans will develop colo-rectal cancer during his lifetime. In Wisconsin there are more new cases of colo-rectal cancer per year than of any other single major malignancy, including lung cancer.[1] In recent years there has been little improvement in five-year survival of patients with colo-rectal cancer. There are practical primary and secondary preventive strategies for this disease which might significantly decrease its incidence and mortality if widely practiced.

The majority of colo-rectal cancer is proposed to be a consequence of our high animal fat, high cholesterol, high calorie, low-bulk diet. Hypotheses based on epidemiologic investigations and recent laboratory studies suggest that in the gut 1) cholesterol is metabolized in carcinogenic metabolites; 2) high concentrations of dietary fat change the composition of bile acids and colonic bacteria, resulting in the production of carcinogenic compounds; 3) cholesterol is converted to its epoxides; and 4) dietary change results in higher mixed function oxidases which alter carcinogenic activity.[2] The role of high residue remains uncertain. Such "dietary" hypotheses require further supporting data before specific dietary changes can be strongly recommended.

Preventive measures should be directed especially toward those patients at greater risk for the development of colo-rectal cancer. Those with a history of one colo-rectal cancer are at significant risk for a second primary; 3.5% will have two synchronous colo-rectal cancers at the time of diagnosis. Persons with polyposis syndromes, such as polyposis coli or Gardner's syndrome, are at high risk. A family history of colon cancer is worrisome; a history of a blood relative with colo-rectal cancer under age 40 or with multiple primaries is particularly significant.[3] Ulcerative colitis or other inflammatory bowel disease precedes approximately 1% of colo-rectal cancers. The presence of both adenomatous and villous polyps suggests a bowel mucosa that has a tendency to form neoplastic lesions. Finally the incidence of colo-rectal cancer increases with increasing age, peaking in the sixth decade of life. The presence of one or more of these risk factors in a patient should prompt formulation of a management plan designed to prevent or diagnose colo-rectal malignancy early, such as the routine use of colonoscopy in patients with ulcerative colitis.

There are two practical preventive measures physicians can take to decrease the incidence of this disease. The first is to insure that certain high risk patients (patients with polyposis syndromes or chronic active ulcerative colitis) undergo appropriate prophylactic surgery.[4] The second, and potentially far more important measure numerically, is for physicians to seek out and remove colo-rectal polyps which are reportedly present in 4% of persons at age 40 and 10% at age 70. For many years the relationship of polyps to colo-rectal cancer has been debated. What has become evident recently is that proctosigmoidoscopic removal of adenomatous polyps is associated with subsequent development of far fewer cancers in that segment of the bowel polypectomized than might be predicted.[5] Physicians performing periodic proctosigmoidoscopies and removing polyps from these patients could prevent most rectosigmoid colo-rectal cancers or about half of all colo-rectal cancers.

One practical method of screening for colo-rectal cancer in asymptomatic patients is to test for fecal occult blood. The refined "Hemoccult II" slide test depends upon the hemolysis of red blood cells in the bowel which releases hemoglobin peroxidases that oxidize an indicator (guaiac) impregnated in the slide. Useful clinical data have come from populations of asymptomatic patients preparing six slides from three consecutive stool specimens while following a special diet high in roughage (thought to promote bleeding from mucosal lesions such as carcinomas) and lacking red meat (containing blood) and peroxidase containing foods which may give "false" positive reactions.[6] Approximately 2% of these patients will have one or more slides test positive. One half of these (1% of all patients) will be found to have neoplastic bowel lesions (polyps or cancers). Thus the "false" positive rate is 1%. The slides must not become dried out before being tested. Theoretical, clinical, and economic considerations suggest that testing at two to three year intervals is practical.

There is no role for the current CEA (carcinoembyronic antigen) serological test as a screening procedure. Elevated values are found in individuals with a variety of neoplastic and nonneoplastic conditions and in healthy persons; thus the test does not separate patients with colo-rectal cancer from others.

Proctosigmoidoscopy is very important as a preventive measure to locate and remove polyps and to identify patients at high risk for cancer by virtue of having polyps.[5] However, in asymptomatic patients over age 40, proctosigmoidoscopy detects a cancer in but 1 of 500 patients examined. A screening proctosigmoidoscopy for polyps every five years is adequate and economical. Patients with rectosigmoid polyps should be investigated with air contrast barium enemas and colonoscopy.

Primary prevention of colo-rectal cancer in the United States in the future may come about through definition and acceptance of a prudent diet (low fat, low calories, high bulk); widespread use of proctosigmoidoscopy (particularly with the new flexible 60 cm instruments which are faster, easier to use, more accurate in de-

Cancer column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701.

Supported by NCI Grant No. 5 R18-CA-16405-03.

tecting polyps, and more comfortable for patients[7] for the removal of detected polyps; and identification of safe consumable chemical substances which interfere with the production of colo-rectal carcinogens in the bowel.[4]

Screening for colo-rectal cancer may become more economical and accurate by the development of a widely usable radioimmunoassay for hemoglobin in stools[8] and a more specific colon tumor marker which can be detected in the blood of patients with "early," asymptomatic tumors.

—RICHARD R LOVE, MD, Wisconsin Clinical Cancer Center

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Cancer Origins

How do tumors originate? This is a question of fundamental importance when considering the mechanism of tumor induction. On reconsidering data previously used on the induction of mammary neoplasms in Sprague-Dawley rats by neutrons,[1] University of Wisconsin scientists[2] concluded that there is currently no reason to reject the simplest hypothesis that one transformed cell is sufficient to produce a mammary tumor in Sprague-Dawley rats.

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2. Gould Michael N, et al: Reevaluation of the number of cells involved in the neutron induction of mammary neoplasms. *Cancer Research* 38:189-192 (Jan) 1978.

—DOROTHY J BUCHANAN-DAVIDSON, PhD ■

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle: the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Oillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Federal Legislation Committee files objections with Nelson, Proxmire

The SMS Committee on Federal Legislation voiced strong objections to Wisconsin's US Senators last month in regard to a bill which would place cost controls on hospital revenues if the Voluntary Effort didn't succeed, and a proposed HEW regulation which would severely limit the amount and method of Medicare reimbursement for medical school faculty.

Robert F Purtell Jr, MD, chairman of the Committee on Federal Legislation, said in letters to Senators Nelson and Proxmire that the Society is opposed to any type of mandatory revenue limitations as contained in Senator Nelson's amendment to Section 2 of the Talmadge Medicare and Medicaid Administrative and Reimbursement Act. Under the Nelson amendment, cost controls would be imposed on hospital revenues if the Voluntary Effort of the American Medical Association and the American Hospital Association fails to reach target percentage figures in restraining costs.

On behalf of the Committee, Doctor Purtell also petitioned the two senators to aid in the repeal of Section 227 of PL 92-603 of the Social Security Amendments of 1972 charging that it would unfairly differentiate between teaching and nonteaching physician in modes of reimbursement for Medicare services.

"If the regulations which HEW proposes under Section 227 were to be implemented, they would seriously endanger the teaching hospitals, possibly forcing physicians to admit their patients into private institutions where physicians could be reimbursed on a fee-for-service basis like their colleagues in private practice, rather than on a cost basis," Doctor Purtell said.

In other action, the Committee on Federal Legislation endorsed reintroduction of the AMA National Health Insurance Proposal, HR 1818 in the next session of Congress. In a mailgram to AMA Executive Vice President James Sammons, MD, the Society urged the AMA to begin emphasizing the bill's provisions for catastrophic coverage for all Americans and insurance for uninsurables in order to "remove the threat of potential financial ruin from a long or serious illness and because such coverage is the most affordable." ■

Practice Management seminars "success"

A somewhat disappointing level of attendance was more than overcome by the marked enthusiasm of the physicians who attended the recent Practice Management seminars.

Participants at all three presentations in Eau Claire, Green Bay, and Madison expressed themselves as being well pleased with the materials and content of the seminar. This is best evidenced by the following summary of evaluation sheets, given out after each topic, which asked for a rating on a scale of 1 to 10, with 10 as a perfect score. In the order in which they were rated, topic scores were as follows:

Accounts Receivable	9.4
Legal Considerations	9.2
Personnel Management	9.1
Patient Management	8.7
Management by Budget	8.4
Collection Practices	8.4
Insuring Yourself	8.0
Legislative Process	7.8
Insuring Your Practice	7.2
Information Systems	7.1
Accounting Controls	6.4

Of 11 topics only one fell below a 70% rating! ■

Health Planning Commission action

The SMS Health Planning Commission, at its meeting September 21, passed a motion urging the State Bureau of Needs Review to utilize physician technical advisory committees in developing the certification rules for specialized hospital services.

Under the decertification law, the State Dept of Health and Social Services has the authority to decertify six specialized hospital services in a given institution if the service is not needed by the community or if the institution is incapable of maintaining the service. These six services are: cardiac surgery/heart catheterization; radiation therapy; hemodialysis treatment of renal insufficiency; kidney transplant; intensive care of high-risk maternal, fetal and neonatal patients, and computed tomography services.

Hilde Neujahr of the State Health Policy Council staff discussed the revision process of the 1978 State Health Plan with the Commission. Ms Neujahr said the revision process won't start until after March 1979 in order to incorporate the local health systems plans of the health systems agencies into the State Health Plan.

The Commission reelected Marvin Parker, MD, Racine, as its chairman and Donald Korst, MD, Madison, as vice-chairman. ■

JUNE 1978 BLUE BOOK UPDATE

In the listing of County Medical Society presidents and secretaries, pages 89-91, the following changes have occurred:

FOND DU LAC: Harry J Colgan, 1215 Doctors Dr, Neenah 54916 is president; and Charles R Lyons, 2000 E Murdock Ave, Oshkosh 54901 is secretary-treasurer. The president-elect is Johan A Mathison, 2121 Bowen St, Oshkosh 54901. ■

Dr. Houlihan named to CME Commission

James T Houlihan, MD, Woodruff, has been appointed to the SMS Commission on Continuing Medical Education.

The Commission consists of the Dean of the University of Wisconsin Medical School, Madison; the Dean of the Medical College of Wisconsin, Milwaukee; and nine appointed members from the State Medical Society. It is responsible for all matters of medical education, from medical school and residency training to lifetime medical education for all physicians.

Doctor Houlihan is a member of the Department of Family Practice at Lakeland Medical Associates, Ltd, and the Howard Young Medical Center. He is director of Medical Education at NYMC, and a member of the Association of Hospital Medical Educators, a national medical education organization. ■

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1978 Work Week of Health emphasizes positive lifestyles

The State Medical Society and its Auxiliary put together this year's Work Week of Health program with the theme "High on Health: Positive Lifestyles."

The program for high school juniors and seniors was broadcast over the public educational television network, October 16-20. More than one-quarter of all Wisconsin high schools and more than 11,000 students planned on direct broadcast participation.

The first three days involved health experts and student representatives who discussed the major areas in which teenagers could develop positive lifestyles and schedule personal health maintenance programs. Terry Hankey, MD, Waupaca, was the program moderator and Darold Treffert, MD, Winnebago, and Patricia Stuff, MD, Bonduel, lead discussions on dealing with stress and food and nutrition, respectively. The remaining two days featured films on contemporary health issues.

Teachers were encouraged to have their students view the program in the schools. The SMS Auxiliary also made available resource material to the schools including: teachers' guides suggesting aids for each program, student activity sheets for each program, and Lifestyle Profiles to help teachers and students assess present lifestyles and develop the healthiest lifestyles possible. Physicians were urged to serve as resource persons in Wisconsin high schools for followup health education programs.

The entire project was developed by the SMS Auxiliary with cooperation from the State Medical Society, State Department of Public Instruction, and the Wisconsin Educational Communications Board. ■

SMS Variable Annuity

. . . Contract Unit Value: The "Accumulation Unit Value" applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $2.54 as of Aug 31, 1978. ■

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1978

5 Dane County Medical Society Board of Trustees
6 Wisconsin Review Foundation
6 Welfare Reform Study Group
7 Subcommittee on Accreditation
8 SMS Realty Board of Trustees
8 Ad Hoc Committee for an Independent Department of Health
8 Joint Practice Committee
11 Dane County Medical Society HMP Committee
12 Uniform Claim Form
13 SMS Commission on Governmental Affairs
13 SMS Committee on Federal Legislation
13 SMS Committee on Environmental Health
13 State Health Insurance Committee
14 Environmental and Public Health Subcommittee of the Health Policy Council
14 South Central District Review Council
15 SMS Physicians Alliance Commission
15 Jail Health Meeting
15 Work Week of Health Planning
19 *Seminar Practice Management (Eau Claire)*
20 WisPRO Executive Committee-Board of Control
20 SMS Committee on Safe Transportation
20 Ad Hoc Committee on Quality Care Activities
21 SMS Commission on Health Planning
21 Council of Professions
22 *SMS Medical Liability Committee (Oconomowoc)*
23 Auxiliary Nominating Committee
24 SMS House of Delegates Nominating Committee
26 WisPRO Review Coordinators Conference
27 Executive Committee-Wisconsin Review Foundation
28 Wisconsin Immunization Initiative Coordinating Committee
29 Wisconsin Public Health Association

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of Sept 26, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

CALUMET

Ganju, Badri N, 251 E Main St, Chilton 53014 (1947, Regular, General Surgery/Emergency Medicine, Certified-GS)

DANE

Cain, G Patrick, 5777 Williamsburg Way, Madison 53719 (1944, Regular, Diagnostic Radiology/Internal Medicine, Certified-R)

Calvert, James F Jr, 850 Terry Pl, Madison 53711 (1945, Resident, Family Physician)

Coleman, Wendy S, 30 S Henry St, 53703 (1945, Regular, Pediatrics, Certified)

Edstrom Lee E, 1300 University Ave, Madison 53706 (1942, Regular, Plastic Surgery, Certified)

Holden, Richard C, 777 S Mills St, Madison 53715 (1949, Resident, Family Physician)

Kehoe, Michael E, 20 S Park St, #504, Madison 53715 (1949, Regular, Internal Medicine, Certified)

Kruse, Diana L, 2302 Chalet Gardens, Madison 53711 (1951, Resident, Orthopedic Surgery/General Surgery)

Kuritz, Robert R, 5714 Odana Rd, Madison 53719 (1950, Regular, Family Physician)

Tillman, Ulder J, 508 Farley Ave, #A, Madison 53705 (1949, Resident, Internal Medicine)

Wenger, Ronald D, 1912 Atwood Ave, Madison 53704 (1944, Regular, General Surgery, Certified)

Woroch, Gary, 1313 Fish Hatchery Rd, Madison 53715 (1949, Regular, Internal Medicine, Certified)

Worsing, Robert A, 3409 Roma Lane, Middleton 53562 (1947, Resident, Orthopedic Surgery)

LACROSSE

Blain, Claude A, 815 S 10th St, La-Crosse 54601 (1929, Regular, Otorhinolaryngology, Certified)

Brennan, John T, Rt #2, La Crescent, MN 55947 (1942, Regular, Internal Medicine/General Practice, Certified-IM)

Smith, William B, 2040 W Wisconsin Ave, Milwaukee 53233 (1944, Regular, Orthopedic Surgery)

Tavaf-Motamen, Ali, 3353 E Ramsey Ave, Cudahy 53110 (1939, Regular, General Surgery, Certified)

Wagner, Alan M, 425 E Wisconsin Ave, Milwaukee 53202 (1949, Regular, Obstetrics and Gynecology)

OZAUKEE

Beecher, Ann C, 11516 N Pt Washington, Mequon 53092 (1943, Regular, Family Physician)

Chemotti, M Thomas, N94 W6539 Fieldcrest, Cedarburg 53012 (1947, Regular, Ophthalmology)

Helz, Timothy J, 32306 West Hwy 16, Hartland 53029 (1948, Regular, Emergency Medicine)

CHANGE OF ADDRESS

(Does not include those within a city)

BARRON-WASHBURN-BURNETT

Matson, Kenneth L, Sarona, to 10738 Santa Fe Dr, Sun City, AZ 85331

DANE

Bozdech, Marek J, San Francisco, CA, to 6233 Countryside Lane, Madison 53705

Hussey, John L, Metairie, LA, to 1430 Tulane Ave, New Orleans, LA 70112

Meschievitz, Carlton, Ashland, to 939A Eagle Heights, Madison 53705

Morrison, Helen L, Madison, to 219 East Lake Shore Dr, Chicago, IL 60611

Olson, Janet E, Westborough, MA, to 10 Tower Rd, Sun Prairie 53590

EAU CLAIRE-DUNN-PEPIN

Enders, Gene G, Menomonie, to 733 W Clairemont Ave, Eau Claire 54701

GREEN

Estes, Glen, New Glarus, to 5413 Bay Ridge Dr, Baton Rouge, LA 70816

Estes, Jeanne M, New Glarus, to 5413 Bay Ridge Dr, Baton Rouge, LA 70816

MILWAUKEE

Ansfield, David J, Milwaukee, to 1410 South Ocean Dr, Hollywood, FL 33019

Bloch, Winston N, Milwaukee, to Hawthorne Hill, Quincy, IL 62301

Mayr, James F, Cincinnati, OH, to 117 Martin Rd, Kittery, ME 03904

Nefches, Michael S, Seminole, FL, to 2020 East Bay Drive, Largo, FL 33541

Peak, Daniel T, Wauwatosa, to John Umstead Hospital, Butner, NC 27509

Pendergast, Robert L, Milwaukee to 3822 Hanson Dr, Dickinson, TX 77539

Redlin, Russell R, Waterford, to 77-500 Interstate 10, Indio, CA 92201

MILWAUKEE

Frazin, Lawrence J, 161 W Wisconsin Ave, Milwaukee 53203 (1946, Regular, Neurological Surgery)

Kuhr, Gregory J, 3615 S 60th St, Milwaukee 53220 (1949, Regular, Family Practice)

Lange, George M, 4432 N Sherman Blvd, Milwaukee 53209 (1948, Regular, Internal Medicine)

Mirviss, Marshal J, 10419 Larkspur Ct, Mequon 53092 (1949, Regular, Internal Medicine)

Reuben, Charles F, 15425 W Burleigh Rd, Brookfield 53005 (1946, Resident, Thoracic Surgery)

Seno, Louis S Jr, 6900 N Pt Washington, Milwaukee 53217 (1949, Regular, Family Physician)

ROCK

Farnsworth, R W, Janesville, to 301 North Ocean Blvd, Pompano Beach, FL 33062

WOOD

Letellier, Marc A, Marshfield, to 1363 Palisades Dr, Appleton 54911

DEATHS

Boren, John W Jr, Marinette-Florence County, Aug 11, 1978

Muenzner, Richard J, Milwaukee County, Aug 27, 1978

Wong, Victor J, Milwaukee County, Sept 9, 1978

Cron, Roland S, Milwaukee County, Sept 12, 1978

Miller, James E, Dane County, Sept 13, 1978

Gueldner, Louis H, Jefferson County, Sept 18, 1978

Housner, Richard E, Richland County, Sept 24, 1978 ■

OBITUARIES

◈County, State, AMA Members

◈ **J William Boren, Jr, MD,** 63, Marinette, died Aug. 11, 1978 in Milwaukee. Born July 6, 1915 in Marinette, Doctor Boren graduated from Northwestern University Medical School in 1940. He served in the United States Army from 1942 - 1946 and returned to Marinette where he was associated with the Boren Clinic. Doctor Boren served as a councilor from the 8th district from 1965 - 1971, served on the Committee on Cancer, and also served on the Commission on Hospital Relations and Medical Education (now the Commission on Health Planning). Surviving are his widow, Zeannette; a son, John W, University of the Philippines, Los-Banos, and a daughter, Mrs Ken (Claudia) Scharnell of Muskegon, Mich. ■

NEWS HIGHLIGHTS

The Max Fox Preceptor

. . . Award recently was given to the late Henry Ashe, MD, Woodruff, posthumously at the sixth annual Day of Country Medicine sponsored by the Howard Young Medical Center in Woodruff. Mrs Ashe accepted the award. Doctor Ashe, a general practitioner, founded the Lakeland Medical Associates clinic in Woodruff over ten years ago and had served as a University of Wisconsin preceptor for ten years. At the time of his untimely death, Feb 12, 1976, he was a councilor of the State Medical Society.

The University of Wisconsin

. . . Medical School Dean Arnold L Brown MD, Madison, recently appointed William E Scheckler, MD,* Acting Chairman of the University's Center for Health Sciences Department of Family Medicine and Practice. Doctor Scheckler graduated from the University of Pennsylvania School of Medicine in 1964 and completed his residency training at the University of Wisconsin, Madison. He is board certified in internal medicine and served from 1968-1970 with the National Communicable Disease Center in Atlanta, Ga. He joined the University of Wisconsin Medical School faculty in 1970. Since 1974, Doctor Scheckler has been a member of the faculty of the Department of Family Medicine and Practice and is currently associate professor of Family Medicine and Practice and Internal Medicine at the Center for Health Sciences.

Wisconsin Surgical Society

. . . at its fall meeting September 14-16, passed resolutions relating to "unnecessary surgery" in Wisconsin and second opinions for surgery. In one resolution the Surgical Society urged the State Medical Society and the State Division of Health to reactivate the Ad Hoc Committee on Elective Surgery to develop a pilot study to determine whether "unnecessary surgery" exists in Wisconsin, and if efforts by third parties to control unnecessary surgery will help or hurt the care of the patient or will increase or decrease the cost of medical care. The Surgical Society also reaffirmed its position that surgical consultation take place when requested by the surgeon or patient; that consultations should be by a physician of similar specialized background with equal or superior knowledge to the primary surgeon; that the patient must have free choice to request, accept, or reject such consultations, and free choice of a qualified consultant, and that the Society opposes reimbursement programs which by financial penalty or financial award coerce the patient to accept unnecessary consultation.

Second opinion "hot line"

. . . toll-free, has been set up by the Dept of HEW to publicize its new campaign to encourage Americans to seek second opinions before agreeing to surgery, according to a recent article in *The Wall Street Journal*. By dialing 800/325-6400 people can ask for the names of doctors in their area to call for a second opinion when nonemergency surgery has been recommended.

Physician recruitment techniques

. . . will be explored during a one-day workshop sponsored by the American Hospital Association November 9 at the O'Hare Hilton Hotel, Chicago. Administrators, physicians, trustees, and community leaders have been urged to attend this workshop designed to highlight several successful recruitment strategies and to allow participants to develop their own plans in consultation with the "experts." Wisconsin hospitals have further details.

Mercy Medical Center

. . . in Oshkosh sponsored an innovative running clinic, "Focus on Fitness," September 15 at the Pioneer Inn. Sessions providing information on fitness and running featured Olympic running coach Arthur Lydiard and UW-Madison psychiatrist John Griest, MD. ■

PHYSICIAN BRIEFS

Gerry K Larmore, MD

. . . Burlington, recently became associated with the Burlington Medical Center. A graduate from the University of Wisconsin Medical School, Madison, Doctor Larmore served his family practice residency at St Mary's Hospital in Madison.

Bruce Hanson, MD

. . . New Richmond, recently joined the New Richmond Clinic, SC medical staff. Doctor Hanson graduated from the University of Wisconsin Medical School, Madison, and finished his family practice residency program at St Mary's Hospital in Madison.

Domenick S Bruno, MD*

. . . Fox Point, has been named president of the St Michael Hospital medical staff replacing Joseph L Teresi, MD,* who was appointed secretary-treasurer. In addition, John P Fetherston, MD,* Fox Point, was appointed vice-president of the medical staff. Doctor Bruno has been a member of the St Michael medical staff since 1958 and has served as chairman of the surgery department and also is a clinical instructor at the Medical College of Wisconsin. Doctor Fetherston has been a member of the medical staff for almost 30 years and was chairman of the hospital's family practice department from 1969-1973.

Robert Lipo, MD*
James Sumners, MD

. . . Greendale pathologist and Milwaukee pediatrician, respectively, recently were appointed to the Council on Infant Health Screening. The Council advises the State Department of Health and Social Services on screening plans to detect metabolic disorders in newborn infants.

Bruce Kraus, MD

. . . recently opened his medical practice in Columbus. He graduated from the University of Wisconsin Medical School, Madison, and served his residency at San Joaquin General Hospital in Stockton, Calif. Prior to opening his office, Doctor Kraus had been serving on the Medical staff of St Mary's Hospital, Madison, and Divine Savior Hospital in Portage.

☐ Copy deadline for NEWS HIGHLIGHTS/PHYSICIAN BRIEFS is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. ☐ Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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8221 W. Brown Deer
Milwaukee

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3090 E. Layton
Cudahy

WEST BEND
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West Bend Plaza
822 S. Main St.

OCONOMOWOC
567-9171
Whiteman Park
1041 Summit Ave.

NEENAH
729-1311
881 S. Green Bay Rd.

SHOREWOOD
961-2000
4081 N. Oakland
Milwaukee

THIENSVILLE
242-3450
Bonnywell Village
278 N. Main St.

MILWAUKEE
464-4600
7713 W. Capitol Dr.

FOND DU LAC
921-5262
88 Forest Ave.

NEW BERLIN
784-4990
3590 Moorland Rd.

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Dr Carey

Dr Ferrazzano

Harold W Carey, MD*

. . . Lancaster, recently was honored by the city and surrounding area for his 42 years of medical practice and for his outstanding contributions and services to the community. "Doc's Day" gave an opportunity of 1000 citizens to express their appreciation for his devotion to and active interest in the betterment of Lancaster. During his years at Lancaster, Doctor Carey delivered over 3,000 babies; served as chief of the Lancaster Memorial Hospital; city health officer since 1945; president of the Grant County Medical Society; served as a delegate to the State Medical Society; vice-speaker for the House of Delegates, and also as a Councilor from the 4th district from 1965 - 1970.

Gabriel P Ferrazzano, MD*

. . . Racine, recently was featured in the *We Salute* column of the RACINE JOURNAL TIMES. Doctor Ferrazzano retired from the position of city health commissioner after serving in that capacity for ten years. He had served in the United States Public Health Service and also was chief of the Division of Hospitals. He was president or chairman of numerous organizations including: Wisconsin Public Health Association; Comprehensive Health Planning Agency of Southeastern Wisconsin; Commission on Public Policy of the State Medical Society of Wisconsin; Racine County Planning Council; Racine County Conference of Agency Executives and on the boards of the Visiting Nurse Association and Lincoln Lutheran Home. In April, the Southeastern Wisconsin Health Systems Agency named him as its outstanding volunteer and in June the Wisconsin Public Health Association cited him for distinguished professional achievement, leadership, and service to the community and the association.

S K Madan, MD

. . . Janesville, recently became associated with E F McNichols, MD.* Doctor Madan, a native of Srinagar, Kashmere, India, served his internship at Mercy Hospital, Des Monies, Iowa; served a three-year residency at Wayne State Hospital, Detroit; was on the medical staff of the emergency room at Harper Hospital, Detroit; and also was on the medical staff of Beloit Memorial Hospital.

Frank J Rubino, MD

. . . Park Falls, recently joined the medical staff of the Murphy Clinic, Ltd, and the Flambeau Medical Center. Doctor Rubino graduated from Loyola University Stritch School of Medicine in 1975 and served a rotating internship at Cook County Hospital, Chicago, where he also completed his residency program in Family Practice.

Nancy Ness, MD
Keith Ness, MD
Lance Zernzack, MD

. . . recently joined the medical staff of Hess Memorial Hospital, New Lisbon, in the Department of Family Practice. Doctors Nancy and Keith Ness graduated from the University of Wisconsin Medical School, Madison, in 1975 and completed their family practice residency program in Eau Claire. Doctor Zernzack also graduated from the University of Wisconsin Medical School, Madison, in 1975 and completed his family practice residency in Madison.

Sharon Maby, MD

. . . a specialist in pediatric endocrinology, recently joined the medical staff of the Marshfield Clinic. She graduated from Downstate Medical College, Brooklyn, and served her internship at Hartford Hospital in Connecticut. Her residency in pediatrics was completed at the Albany New York Medical Center Hospital. ■

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FAMILY PRACTICE OR PRIMARY care physicians, urgently needed for large multispecialty clinic in southern Wisconsin currently developing a satellite program in surrounding area. Excellent opportunity with chance to develop your own practice within the group. Send replies to T E Peters, MD, The Monroe Clinic, Monroe, Wis 53566. Tel: 608/328-7000. 7-9/78

FAMILY PRACTITIONER, PHYSiatrist and ENT physician needed by 31-man multi-specialty clinic next to 350-bed hospital. Fifty thousand population city in beautiful Mississippi River Valley with sophisticated medicine and excellent cultural attractions. William J O'Leary, MD. 815 South 10th St, LaCrosse, Wis 54601. Tel: 608/782-9760. 7tfn/77

INTERNIST-OB/GYN-FAMILY practice-pediatric practice openings available in growing multispecialty group. Progressive, expanding community of 25,000 located 30 miles north of Milwaukee. Many corporate benefits. Modern hospital facilities. Inquire: General Clinic of West Bend, Inc, PO Box 178, West Bend, Wis 53095. 7tfn/78

TWO FAMILY PRACTITIONERS urgently needed to join established group in one of the fastest growing areas of western Wisconsin. Ideal mix between farming, industry and outdoor recreational and resort area, short drive by freeway to Minneapolis and St Paul. 84-bed JAHA approved hospital and nursing home complex. Salary $40,000+, full partnership after a year, without investment. Contact Richard L Hartzell, MD, Grantsburg Clinic, Ltd, Box 169, Grantsburg, Wis 54840 (715/463-5317) or Frank Snapp, Admin, Burnett General Hospital, Grantsburg, Wis (715/463-5353). 10-12/78,1/79

PEDIATRICIAN. IMMEDIATE need for a full or part-time pediatrician and family practitioner to provide services to the Native American community in Milwaukee, Wis. Comprehensive medical, dental, psychiatric, social services and health related legal services are provided in a newly remodeled multi-service health center on an out-patient basis. Compensation includes salary, travel, benefits and paid malpractice insurance. Wisconsin license required. For more information write or call collect Dr A Gima, Milwaukee Indian Health Board, Inc, 930 N 27th St, Milwaukee, Wis 53208. Tel: 414/931-8111. 10tfn/78

THE WAUSAU MEDICAL CENter, SC, *a multi-specialty group (including Family Practice)*, is looking for physicians in the following areas of practice:

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- Neurology
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BOARD CERTIFIED, OR BOARD eligible, pediatrician wanted in Wisconsin multispecialty group of 26. College town of 35,000 between Madison, Milwaukee, and Chicago. New clinic building adjacent to new hospital. Very competitive income. Write: W S Freeman, MD, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, Wis 53511. 7-12/78

WISCONSIN-GREEN BAY. FULL time position open for a hospital based Emergency Room physician. Attractive opportunity in emergency department with 21,000 plus yearly visits. Pleasant medium size city with excellent recreational areas nearby. Salary $58,000 plus paid malpractice and complete benefit program (paid vacation, educational leave, life insurance and pension plan). Submit CV to: Administrator, St Mary's Hospital Medical Center, 1726 Shawano Ave, Green Bay, Wis 54303. 10-11/78

PHYSICIAN WANTED—GENERAL and family practice to join me in my established practice. Northeast resort area of Door County. Excellent potential. Contact: Nicholas R Wagener, MD, 802 N 3rd Ave, Sturgeon Bay, Wis 54235. 8-12/78,1-2/79

PSYCHIATRIST TO JOIN A CMHC serving 100,000 population in five rural counties of NW Wisconsin. Eclectic staff of 35; new OP facility; salary $37,000 minimum with full fringe. Vacation area with many recreational activities. Call or write to: Program Director, Northern Pines Unified Services Center, 715/822-4747 or Box 518, Cumberland, Wis 54829. 8-10/78

DERMATOLOGIST—CITY OF BURlington, Wis. New office building. 150-bed modern hospital. 25 staff physicians, only hospital in radius of 25 miles. 80 miles from Madison and Chicago and 35 miles from Milwaukee. Assistance in start-up. Contact Arthur McCourt, Burlington Commercial Ent, 148 S Pine St, Burlington, Wis 53105 or call collect 414/763-7697. 8-10/78

UNIVERSITY OF WISCONSIN, Madison—Chairperson of the Department of Medicine. The University is seeking applicants/nominees for the position of Chairperson of the Department of Medicine. The qualifications include a background in internal medicine, demonstrated superior skill in administration and medical education and an established record as a scholar in medical science. It is highly desirable that the candidate be experienced in working with other clinical and basic science disciplines within the school of medicine as well as with community physicians. The University of Wisconsin System is an Affirmative Action and Equal Opportunity Employer. Applications or nominations should be sent to: Henry C Pitot, MD, PhD, Chairman, Search and Screen Committee, McArdle Laboratory, University of Wisconsin, Madison, Wis 53706. Closing date for applications/nominations is Dec 15, 1978. 10/78

INTERNIST OR GENERAL PRACtice physician for the staff of a Health Care Facility in a city of 43,000 in north central Indiana. Permanent license in any United States required. Salary open to $47,025 depending on qualifications and experience. Special bonus pay is available in addition. 30 days vacation; 15 days sick leave; 9 paid holidays; low cost life and health insurance; malpractice insurance furnished; excellent retirement plan. Moving expenses paid. EOE. Contact: Personnel Service, VA Medical Center, Marion, IN 46952. Tel: 317/674-3321, ext 419 collect. 10/78

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WANTED: FAMILY OR GENERAL practitioner to serve East Central Wisconsin small college town of 7,000, close proximity to community hospital with up-to-date facilities. Guaranteed base income with opportunity for partnership. Call or write for details to R S Pelton, MD, 315 Mt Zion Dr, Ripon, Wis 54971. Tel: 414/748-2875. 10tfn/78

PEDIATRICS, FAMILY PRACTICE, internal medicine, urology and ENT positions available with a 13-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 9-12/78

GREEN BAY. OPPORTUNITY FOR a primary care internist or family physician to join a 3-man group. Full partnership available second year. Contact: John Brusky, MD, 1203 S Military Ave, Green Bay, Wis 54304. Tel: 414/494-4781. 1tfn/78

FAMILY PRACTITIONERS: TWO young, board certified family physicians seek one or two board eligible or board certified family practitioners to join busy, three man group (one member leaving) in Watertown, Wisconsin, a community of 18,000, located within one hour of Madison and Milwaukee. Immediate opening. Guaranteed income. If interested, contact Watertown Family Practice Associates, 123 Hospital Drive, Watertown, Wis 53094. Tel: 414/261-8500. 6tfn/78

INTERNIST WITH AN INTEREST in cardiology. Minneapolis-St Paul internists' group seeks associate who wishes to weight his practice with noninvasive cardiology. Electrocardiography, active coronary care responsibilities, and resident teaching responsibilities in contacts of group practice. Curriculum vitae and references mail to Dept 459 in care of the Journal. 7-12/78

INTERNIST, 29, FMG, SEEKING relocation. Available immediately. Contact Dept 462 in care of the Journal. 10/78

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CONTINUING MEDICAL EDUCATION MEDICAL MEETINGS

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 WISCONSIN

Nov 2-3: *Alcoholism is a Woman's Issue,* a public conference in Madison, sponsored by the Wisconsin Association on Alcoholism and Other Drug Abuse, Inc. Info: Hilary Freeman, Women's Alliance Project of WAAODA, 333 W Mifflin St, Madison, Wis 53703 (608/257-7970).

Nov 3: *The Adolescent in Therapy,* at Hoffman House-Midway Motor Lodge, LaCrosse. Info: Gundersen Medical Foundation, Ltd, 1836 South Ave, LaCrosse, Wis 54601.

Nov 3: *Pediatric Emergencies,* Fall Pediatric Day, Wisconsin Chapter, *American Academy of Pediatrics,* Wisconsin Center, Madison, Wis 53706

Nov 15-17: Amipaque Myelography and New Techniques in Neuroradiology, UW-Madison. Fee: $190. Contact: Lyn Apfel, 465B WARF Bldg, 610 N Walnut St, Madison, Wis 53706. Category 1 approved.

Nov 18: *Wisconsin Dermatological Society,* Milwaukee County General Hospital, Milwaukee, Wis 53202

Nov 21: *Milwaukee Academy of Medicine,* 1020th meeting, University Club of Milwaukee, Milwaukee. Visiting professor and guest speaker: Dr Andre E Hellegers, Professor of Obstetrics-Gynecology, Physiology and Biophysics, Georgetown University, Washington, DC. DIAL 414/257-8249 for reservations and cancellations. Nonmember physicians welcome.

1978 OTHERS

Nov 14-17: Thirty-second World Medical Assembly, Manila, The Philippines. Info: World Medical Association Inc, 13 Chemin du Levant, 01210 Ferney-Voltaire, France. *Without delay.*

Dec 4-8: *Fluid and Electrolyte Balance, Hypertension and Renal Diseases,* American College of Physicians Postgraduate Course, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Ill. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

1978 AMA

Dec 2-6: House of Delegates Interim Meeting. Chicago.

Dec 7-10: Winter Scientific Meeting. Las Vegas.

1979 WISCONSIN

Jan 4-10: Medical College of Wisconsin annual postgraduate course in *Gynecological Pathology, Cytogenetics and Endocrinology,* at Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Jan 17-19: 9th Annual Winter Refresher Course for Family Physicians at The Pfister Hotel and Tower, Milwaukee.

Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233. Tel: 414/933-0700.

Feb 13-14: Wisconsin Chapter, American College of Emergency Physicians, Alpine Valley Resort, East Troy. Subject: Cold injuries—recreational and industrial.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835.

May 18-23: Annual Meeting of American Holistic Medical Association at University of Wisconsin - LaCrosse. Info: Rt 2, Welsh Coulee, LaCrosse, Wis 54601. Tel: 608/786-0611.

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

18th National Conference on the Detection and Treatment of Breast Cancer

Mar 5-8, 1979 • Atlanta, Ga

Conference devoted to progress in detection and treatment of breast cancer. To feature internationally recognized authorities in the fields of radiology, surgery, pathology, obstetrics and gynecology, epidemiology, and other medical and nonmedical specialties.

Emphasis placed on team approach to cancer management and involvement of various specialties in major problem areas including: high-risk benign disease, minimal breast cancer, radiation risks, detection programs, invasive cancers, the relationship of gynecological disease and breast disease, and rehabilitation.

Sponsored by American College of Radiology. Co-sponsored by College of American Pathologists, Educational Foundation of the Society of Plastic and Reconstructive Surgery, American Academy of Family Physicians, in cooperation with American College of Obstetricians and Gynecologists.

Approved for Category I credit under the AMA continuing medical education criteria.

Further info: American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, MD 20015. Tel: 301/654-6900.

May 3-5: Wisconsin Chapter: American Academy of Pediatrics, Pioneer Inn, Oshkosh, Wis 54901.

1979 NEIGHBORING

Mar 5-8: *Neurology for the Internist,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Mar 7-9: Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists, Conrad Hilton Hotel, Chicago.

May 16-18: *Cardiac Auscultation and Cardiac Examination,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St, Philadelphia, Pa 19104.

1979 OTHERS

Jan 25-27: *National Conference on Forensic Medicine and Society,* sponsored by American Society of Law & Medicine and the Pittsburgh Institute of Legal Medicine, at the Hotel del Coronado, outside San Diego, Calif. Info: ASLM, *Forensic Medicine and Society,* 454 Brookline Ave, Boston, MA 02215.

Mar 4-6: Winter Pediatric Conference, sponsored by Marshfield Clinic Department of Pediatrics, at Powderhorn Ski Lodge, Bessemer, Mich. Info: H James Nickerson, MD, Chairman, Dept of Pediatrics, Marshfield Clinic, Marshfield, Wis 54449.

9th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

Jan 17-19, 1979

The Pfister Hotel and Tower, Milwaukee

Sponsored by the Department of Family Practice, The Medical College of Wisconsin and Southeastern Chapter of the Wisconsin Academy of Family Physicians

Course Director: *Thomas F Garland, MD,* Associate Professor of Family Practice, Program Director, Family Practice Residency Program, Deaconess Hospital

Approved 21 credit hours of CME Category 1 credit by the AMA-PRA

Info: Mrs Susanna Rechlitz, Conference-Manager, Department of Family Practice, 610 North 19th St, Milwaukee, Wis 53233. Tel: 414/933-0700

Apr 4-6: National Conference on High Blood Pressure Control, The Washington Hilton, Washington, DC. Sponsored by the National High Blood Pressure Education Program Coordinating Committee. Info: Conference Headquarters, NCHBPC, 1501 Wilson Blvd, Suite 600, Arlington, Va 22209; tel 703/527-4500. g9/78-2/79

Apr 4-6: American Cancer Society, National Conference - Urologic Cancer, 1979. Los Angeles Hilton Hotel, Los Angeles, CA. Info: Urologic Cancer Conference, American Cancer Society, 777 Third Ave, New York, NY 10017.

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

Oct 30-Nov 12

The Challenge of Adolescent Medicine: Six Patients, with Robert Masland, Jr, MD, Assistant Professor of Pediatrics, Harvard Medical School and Chief, Division of Adolescent Medicine, The Children's Hospital Medical Center, Boston; Norman Spack, MD, Instructor in Pediatrics at The Children's Hospital Medical Center, Boston; and Estherann Grace, MD, Clinical Instructor in Pediatrics Harvard Medical School and Assistant in Medicine (Adolescent Medicine), The Children's Hospital Medical Center, Boston. Acceptable for Category 1 credit by the American Medical Association and by the AAFP for Prescribed Credit.

Nov 13-Nov 26

Anemia: Signal of Disease, with Gerald Rothstein, MD, Associate Professor of Medicine, Division of Hematology, University of Utah College of Medicine. Acceptable for Category 1 credit by the American Medical Association and by the AAFP for Prescribed Credit.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Jan 27-31: American College of Allergists, San Francisco. Info: F P White, 2141 14th St, Boulder, CO 80302.

Mar 22-29: American Society of Clinical Pathologists and College of American Pathologists, New Orleans. Info: J L Normoyle, 2100 W Harrison St, Chicago, Ill 60612.

Apr 2-5: American College of Surgeons, (Spring Meeting), Denver. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Apr 26-29: Annual Meeting, American Society of Internal Medicine, New Orleans, La.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

THE ADOLESCENT IN THERAPY

Friday, Nov 3, 1978

Midway Motor Lodge
1835 Rose Street
LaCrosse, Wis

Presented by LaCrosse Lutheran Hospital and Gundersen Medical Foundation, Ltd

Program:

am
- 8:45 Registration
- 9:15 Introductions and Welcome *David C Prindle, ACSW*
- 9:30 "Differential Diagnosis" *Larry S Goodlund, MD*
- 10:30 Coffee Break
- 10:45 "Individual Psychotherapy of Adolescents" *Jack V Wallinga, MD*
- 12:00 Luncheon

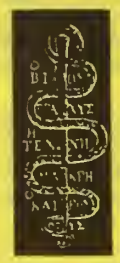
pm
- 1:00 "Family Therapy of Adolescent Problems" *David V Keith, MD*
- 2:00 Coffee Break
- 2:15 "Inpatient Treatment of Adolescent Problems" *Allen L Hauer, PhD*
- 3:15 Wrap Up

Registration deadline: Oct 27.

Program fee $25. Approved 4 hours of CME Category 1 credit by the AMA-PRA. Info: Medical Education Office, Gundersen Clinic, Ltd, 1836 South Ave, LaCrosse, Wis 54601.

American Society of Internal Medicine Future meetings:

April 26-29, 1979	Annual Meeting	New Orleans, Louisiana
Sept 28-29, 1979	Interim Meeting	Las Vegas, Nevada
May 15-18, 1980	Annual Meeting	Washington, DC
Sept 26-27, 1980	Interim Meeting	San Diego, California
April 30—May 3, 1981	Annual Meeting	Denver, Colorado



CONTRIBUTIONS—CES FOUNDATION
August 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1978.

Unrestricted

H Kent Tenney, Jr, MD; John Allen, MD—*Voluntary Contributions*

Restricted

NMC Projects, Inc—*General Scholarship Fund*
Robert L Hendrickson, MD—*Medical Student Summer Externship Program*
Membership Dues—*Aesculapian Society*

Memorials

Dr-Mrs Robert A Starr—*Harold Hoffland (Student Loan Fund)*
Mr-Mrs HB Maroney—*Kelly Ann Dempsey (Barbara Scott Maroney Memorial Fund)*
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State Medical Society—*Frank Urban, MD; LT Schlenker, MD; Paul K Edwards, MD; George L Thomas, MD; Willard C Sumner, MD*

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION of the *Wisconsin Medical Journal*, issued monthly.

PUBLISHER: State Medical Society of Wisconsin, 330 East Lakeside Street, Madison, Wisconsin 53715

MEDICAL EDITOR: V. S. Falk, MD, 5 West Rollin Street, Edgerton, Wisconsin

MANAGING EDITOR: E. R. Thayer, 330 East Lakeside Street, Madison, Wisconsin

OWNER: Same as publisher above.

KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES: None.

THE PURPOSE, FUNCTION, AND NONPROFIT STATUS OF THIS ORGANIZATION AND THE EXEMPT STATUS FOR FEDERAL INCOME TAX PURPOSES have not changed during the preceding 12 months.

EXTENT AND NATURE OF CIRCULATION	AVERAGE NUMBER COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NUMBER OF COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
Total number copies printed (net press run)	5592	5650
Paid circulation (mail subscriptions)	5319	5330
Total paid circulation	5319	5330
Free distribution by mail, carrier or other means (samples, complimentary, and other free copies)	177	205
Total distribution	5496	5535
Office use, left-over, unaccounted, spoiled after printing	96	115
TOTAL	5592	5650

I certify that the statements made by me are correct and complete,
/s/ MARY ANGELL
Assistant Managing Editor

Date of filing: Sept. 18, 1978
PS Form 3526, modified above for purposes of printing.

First International Congress on Cardiovascular Diseases

JOINT MEETING WITH THE

American Society of Contemporary Medicine and Surgery

14TH ANNUAL SCIENTIFIC ASSEMBLY

Doctors Michael DeBakey, Eliot Corday, and Norman Kaplan will chair the FIRST INTERNATIONAL CONGRESS ON CARDIOVASCULAR DISEASES, to be held jointly with the 14th Annual Meeting and Scientific Assembly of the American Society of Contemporary Medicine and Surgery

Jan 14-19, 1979—Las Vegas, Nev

CAESARS PALACE

The premier convention of this newly formed organization will take place on Monday, January 15 and Tuesday, January 16, and will feature distinguished speakers from Europe, Japan, Israel, South America, and the United States. The lecturers will discuss topics of particular interest for the practicing clinician in two areas: CARDIOVASCULAR DISEASES, and HYPERTENSION.

The 1979 meeting of the ASCMS will also include the following seminars: Wednesday, January 17: **ONCOLOGY, R Lee Clark, MD** and **Joseph T Painter, MD**, chairmen. Thursday, January 19: **NUTRITION, George L Blackburn, MD**, chairman. Friday, January 19: **RHEUMATOLOGY, Andrei Calin, MD** and **James F Fries, MD**, chairmen. This week long program

MEETS CRITERIA FOR UP TO 40 HOURS OF CME CREDIT IN CATEGORY I FOR PRA AWARD, AND 30 ELECTIVE HOURS AAFP.

For information, write: Rutledge W Howard, MD, CME Director, American Society of Contemporary Medicine and Surgery, 6 North Michigan Ave, Chicago, Ill 60602.

TITLE 19 REIMBURSEMENT LEVELS INCREASED

The Title 19 (Medicaid) fiscal intermediary, EDS Federal Corporation, has raised the reimbursement level to physicians for Title 19 services 5.08 percent beginning Sept 20, 1978. This change coincides with the increase the Dept of Health, Education, and Welfare approved for the Title 18 (Medicare) Program last July for fiscal year 1979.

STILL TIME TO ORDER IMMUNIZATION AWARD CERTIFICATES

MacDonald immunization award certificates are still available from the SMS Auxiliary office in Madison. The certificates are part of a massive campaign to get children properly immunized before school starts in the fall of 1979. To date more than 137,000 certificates have been distributed to physicians' offices for use by their young patients.

SMS OFFERS SPRING CARIBBEAN CRUISE TO MEMBERS

The State Medical Society has endorsed for its members, a spring cruise to the Caribbean, including visits to San Juan, Puerto Rico, Curacao, Caracas—Venezuela, Trinidad, and St Thomas. The cruise is scheduled for Feb 17-24, 1979. For more information contact Dittman Tours, Inc, at PO Box 199, Northfield, MN 55057, or Peter Wood at SMS Madison offices.

WHERE TO SEND CATEGORY I CREDIT DOCUMENTATION

Physicians are reminded to send in their documentation of Category I Continuing Medical Education to: MEDICAL EXAMINING BOARD, 1400 East Washington Ave, Madison, WI 53703. Members of the Wisconsin Academy of Family Physicians (American Academy of Family Physicians) should send their Category I credit documentation to: Mr Robert Herzog, Executive Secretary, WISCONSIN ACADEMY OF FAMILY PHYSICIANS, 850 Elm Grove Road, Elm Grove, WI 53122. *Physicians are not to send this information to SMS!*

NEW QUALITY ASSURANCE PROJECT REVIEWS NURSING HOMES

The State Division of Health informs physicians that a new concept in government regulation of nursing homes is now being demonstrated in western Wisconsin by the Division's Quality Assurance Project (QAP). The project will document the effect of reallocating, in a more efficient and effective manner, the state resources involved in annually surveying nursing homes. Currently, there are two required reviews: the facility survey (for licensure and participation in Medicaid); and the Medicaid patient review (for appropriateness of placement and level of care). These two reviews are "one hundred percent reviews;" that is, each applicable state and federal regulation is reviewed, and each Medicaid patient's care is assessed. The QAP reviews, however, encompass a screening survey and an indepth review of the care of a sample of all nursing home residents (regardless of pay-type) to identify problem areas. The screening enables the State to focus resources more effectively and efficiently so that the amount of time spent in a home is in proportion to the number and severity of problems found. For example, state surveyors have additional time and energy to spend on documenting regulations out of compliance or on providing consultation to homes needing technical assistance. QAP will run until December 1980. Before the end of the project, a number of homes in the Milwaukee area will be surveyed using the QAP methods. If physicians would like further information about QAP, they can contact the Quality Assurance Project office, 131 West Wilson St, Room 905, Madison, WI 53703. ■

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN MEDICAL JOURNAL
1903 · 1978 75th ANNIVERSARY YEAR

USPS 688-360
Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

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NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc, 711 South Blvd, Oak Park, Ill 60302. Ph 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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State Medical Society of Wisconsin

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Front Page Update

PSYCHOTHERAPY PRIOR AUTHORIZATION REVIEWED

A peer review group for prior authorization for continuing psychiatric care for Title 19 patients has been established by the State Department of Health and Social Services. The group consists of a psychiatrist, PhD psychologist, and a Masters of Social Work. They will be reviewing all cases requiring prior authorization under PW- MA 25, the Psychotherapy Rule which states that any Title 19 recipient is eligible for psychotherapy services up to 15 hours per calendar year or $500 per calendar year—whichever comes first. Beyond this amount, prior authorization must be obtained before Title 19 reimbursement will be given for continuing treatment.

FLU VACCINE AVAILABLE FOR ELDERLY, HIGH RISK PATIENTS

The State Division of Health has been given 90,000 doses of flu vaccine which will be available free to elderly state residents and those with health risks. Vaccinations will be free from public health agencies and private physicians; however, physicians are entitled to charge for office calls. The vaccine will protect individuals against the A/USSR/77, A/Texas/77, and B/Hong Kong/72 strains. It may be administered to persons more than 65 years of age and to those with heart disease, pulmonary disease, chronic renal disease, diabetes mellitus, chronic anemia, and health problems which inhibit the body's immunity system. For information concerning the influenza immunization, physicians should contact: Immunization Program, Bureau of Prevention, Division of Health, PO Box 309, Madison, WI 53701; tel (608) 266-2346.

CHIROPRACTORS BOARD INTERPRETS SCOPE OF PRACTICE

The Chiropractic Examining Board has formally declared the "collection of urine and the drawing of blood for testing as well as the interpretation of these tests for analytical and diagnostic purposes to be lawfully within the scope of a chiropractor's diagnostic procedure. It made the decision on the basis that state law or regulations permit chiropractors to use diagnostic and analytical instruments and procedures approved by the chiropractic board and taught in chiropractic colleges. In light of this action by the board, the SMS Governmental Affairs Commission has decided to explore possible legislation to change the Chiropractic Practice Act.

HEARING PROCESS ON "SUPER RULE" TO BEGIN

The Wisconsin Department of Health and Social Services last month issued the final draft of the Medical Assistance Rules of Wisconsin—commonly referred to as the "Super Rule." The Rule now goes to the Legislature for public hearings and review. The legislative committee hearings are very important, since the committee can suggest changes, deletions, and/or additions to the Rule to the Department of Health and Social Services. The SMS Physicians Alliance Division and its T-19 Oversight Committee now are reviewing the proposed Rule and preparing comments for the legislative hearings. All county medical societies are being mailed a copy of the Super Rule and are urged to offer their comments to the T-19 Oversight Committee in care of the Physicians Alliance Division in Madison. ■

Editorials

Editorial Director: WAYNE J BOULANGER, MD

Professional parasites

LAST YEAR A Milwaukee County circuit judge addressed a group of Wisconsin surgeons. He had been impressed with the number of civil suits resulting from so-called whiplash injuries following automobile accidents. He instituted an investigation and was even more impressed when he learned that the vast majority of these suits involved a single attorney and a single physician who submitted monumental bills for "therapy." The judge persevered in his investigation and ultimately the physician lost his license to practice medicine in Wisconsin.

Also last year a Miami TV station was running a documentary on whiplash injuries. The investigating commentator found that again an inordinately high percentage of these suits resulting from that type of injury involved a single attorney and a single physician. During the course of the documentary series and quite by coincidence, the TV commentator was rear-ended and sustained a whiplash injury. His car had scarcely stopped from the impact of the collision when a total stranger popped his head through the car window and said that he had witnessed the accident. He also said it was essential that the driver who had been struck from behind must see a specific attorney. The commentator indicated that he was not seriously injured and did not intend to pursue it. At that point the witness said, "If you do not see this particular attorney, I will testify that the accident was entirely your fault." Apparently the attorney had a host of runners or opportunists blanketing Miami.

But even worse than the conspiring attorney-physician combine, is that perennial parasite, the professional witness-for-hire. He is that remarkable paragon who can pontificate from afar on so many aspects of medicine. It is true that by definition an expert medical witness is anyone who is considered to have greater knowledge than a lay person and does not necessarily have a practice similar to the physician defendant.

Certainly there are two sides to every controversy, and it is inevitable that some physicians will appear in adverse situations and that there are truly honest differences in opinion. However, when the same "expert witness" appears repeatedly in a wide variety of cases involving medical liability, there arises a question as to that individual's omniscience.

A survey of those physicians who appear as "expert witnesses" would probably reveal an interesting pattern of repetition. Most physicians are reluctant to appear in court under any circumstance, sometimes resulting in cries of a "cloak of conspiracy." Ultimately there may be legislation that could require by law disinterested physicians to evaluate claims and testify under oath before formal panels.

In a suing society with a devotion to litigation and an over-populated plaintiff's bar, the medical profession does not need to be albatrossed with professional parasites.—VSF

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

More inconsistency

THE FEDERAL DEPARTMENT of Health, Education, and Welfare, supposedly promoting the Government's goal of hospital cost containment, has come up with another gross inconsistency. The situation involved the construction of a 24-bed hospital in a small Wisconsin community. This was to replace the present facility, also 24 beds, which was outmoded and in need of extensive repair.

The Wisconsin Division of Health turned down the hospital's request in 1976, ruling that no new hospital should be built in that area because sufficient hospital beds were available nearby. The State also pointed out that if a new hospital were to be built, it could not expect to achieve a reasonable occupancy rate. The initial decision was appealed by the hospital and went to a hearing in which the hearing officer found fault with several points raised by the State but did not specifically overrule the State. Then the whole matter went to HEW, which in 1977 had upheld the State's decision against the hospital. The hospital then sued the HEW, and on September 1 HEW gave notice that it was reversing its original position and was withdrawing from the case.

A spokesman from the Wisconsin Division of Health said that HEW's withdrawal from the case "evidences a total lack of support for health planning."

Without becoming involved in the local controversy and not knowing about the community's needs, it still appears that the Federal agency talks a good game but continues to be inconsistent as far as possible cost containment is concerned. —VSF ■

Opinion/Dialogue

Last word on provider contract

NOW THAT THE dust has settled a bit following the hassle over the Title 19 provider contract, perhaps a few observations ought to be made.

First of all it seems clear that most Wisconsin physicians, even those who signed the contract without much argument, feel uneasy about its wording and the possibility that they have agreed to abide by the contract even if the State makes later changes without provider approval. The knowledge that either party may be released from the contract with appropriate prior notice ameliorates that concern, but not entirely.

It also seems clear that among the 20 percent of Wisconsin physicians who didn't sign are a significant number who are objecting as much to Title 19 itself as they are to the contract, and find not signing the contract a convenient way out. In a free enterprise system that is as it should be, as long as the patients have access to satisfactory service. Title 19 with its fraud, its abuses, its mountains of paperwork, its discounted payments and its inequities is a milestone around all our necks and has done much to take the joy out of practicing medicine.

A bit less obvious but no less important is the failure of the Council to take a strong leadership role in the decision-making process when so many of our members were calling for guidance on whether to sign the contract. Our Council's excuse in failing to make a firm recommendation one way or the other was that our legal counsel had advised against it. But if the State Medical Society, through Council action, can't legally advise its own members on a matter of medical practice, what good is the Society? There are times when following legal counsel may be the safer route, but in this case it was wrong.

Fortunately, all this experience gained in the battle over a temporary contract ought to serve us well when the Super-rule, designed to replace the temporary provider contract, is promulgated. Let's hope we can stand together and achieve a satisfactory arrangement, and this time let's insist that our leaders take a stand!

WAYNE J BOULANGER, MD
Councilor, First District
Milwaukee

EDITOR'S NOTE: Our leaders *have* taken an extremely strong stand. You don't need to speculate on that. This time it is "a good contract" or we recommend that it would be disadvantageous to sign. And I'm convinced that to have done this last time would have precipitated a lawsuit over the wrong issues at the wrong time.—ERT

Medical fees

THE PUBLIC AND state medical community were informed June 1, 1978 that Surgical Care Blue Shield was arbitrarily instituting a 5% "cap" to fees it would pay for medical services, effective immediately. Much as we would all like to see inflation halted, it is currently projected at an 11% annual rate while costs of conducting a medical practice may be increasing at an even faster rate. Surgical Care Blue Shield is also increasing its charges to subscribers at an announced 11-12% rate this year. It did not announce any effect on its employees' salaries.

Since Surgical Care Blue Shield has followed the "customary, reasonable, and usual" concept in the past, and I think, written it into its subscribers' contracts, it may have been in error in announcing that it would de-

fend its subscribers in the courts if they were asked to pay fees that had increased faster than 5% annually. Accordingly I have informed each of my patients by letter and/or by personal discussion that no third party payer may arbitrarily determine medical fees, and that any dispute regarding third party payments are between the subscriber and his insurer. A copy of that letter is enclosed (see below).

I suggest that all Wisconsin physicians take similar action, and that the State Medical Society condemn Surgical Care Blue Shield for its arbitrary, capricious, and arrogant action.

MARTIN FRUCHTMAN, MD
Waukesha

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Community Health

PART 1

THE HEALTH PROMOTION PROGRAM outlined has been adopted by Wisconsin's Task Force on Health Screening and Immunization as its "official" recommendation to practicing physicians. The Task Force acknowledges that the inclusion of certain tests and the exclusion of others was determined by somewhat arbitrary standards. These criteria have been outlined so that individual physicians can evaluate other diseases and screening tests and determine whether to include them in the program recommended to individuals in his or her practice. This allows physicians to develop a program compatible with his or her style of practice without sacrificing the principles underlying a good health promotion program. It is the consensus of the Task Force that a program designed along these guidelines represents organized medicine's best attempt to provide a health promotion program for individuals. The Task Force encourages physicians to modify and implement such programs.

Planning and implementing a health promotion program

through individual, physician, and community responsibility

TERRY L HANKEY, MD, Waupaca, Wisconsin

OVERVIEW: General concepts and certain essential guidelines of health for a comprehensive health maintenance program are discussed. To apply these concepts and guidelines in primary practice, it is necessary to mesh a basic understanding of health maintenance with an understanding of the natural history of disease, the aging process, the family life cycle, the predictable life stresses of an individual, and community influences.

Doctor Hankey is Chairman of the Task Force on Health Screening and Immunization. Reprint requests to: Communications Dept, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

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ALTHOUGH HEALTH maintenance has been promoted in recent years[1] as an obligation of the health care system, there is still much controversy about what constitutes a good health maintenance program are discussed. To systems have been recommended with very little reliable research data to support their efficacy. This paper outlines some guidelines for a health maintenance system. Within these guidelines there is sufficient flexibility for an individual practitioner to design a program reflecting his or her own philosophy, training and style of practice, as well as the special needs of the person actually served.

A health maintenance program begins with some consensus of what constitutes good health. It's not enough to define good health as just the

absence of medical illness. Health encompasses a spectrum of degrees of well being all the way from dying to living with disease, to disease-free living, to the optimum goal of enhanced living or living with enjoyment, satisfaction, and productivity.

A health promotion program then includes disease prevention by such means as immunization, patient education, prophylactic treatment for certain conditions, and screening for otherwise undetectable diseases. It also helps people by teaching basic facts about staying healthy through patient education, anticipatory counseling and family planning. An additional dimension to health promotion which helps individuals be happy through life-enhancing activities such as exercise, hobbies, religion, art, travel, adventure or whatever, gives individuals deep and lasting satisfaction beyond just being free of disease.

For a health maintenance program to meet these goals it must become a continuous part of a person's life. One-time screening clinics and one-shot executive physicals cannot substitute for a continuous life-long program in health maintenance. Even basic disease prevention is not accomplished in a program which is not continuous. A person who screens negative for diabetes today may develop the disease in the future. A program which is not continuous may lead a patient to ignore significant symptoms. Health promotion needs change as a person passes through chronologic age with its changing risk for specific diseases. Needs change also with different phases of the family life cycle and with the predictable maturing phases of adulthood.

"Within these guidelines there is sufficient flexibility for an individual practitioner to design a program reflecting his or her own philosophy, training and style of practice, as well as the special needs of the person actually served."

Not only must a health promotion program be continuous but also it must be comprehensive in the sense that it addresses all significant and preventable diseases. Significance may be arbitrarily judged on the basis of incidence, prevalence, morbidity or mortality. Certainly where dollars and cents decisions must be made regarding what units of health care can be delivered to large segments of our population, high priority must be placed on those illnesses which inflict the most suffering and which are the most common threats. Preventability is a state-of-the-art assessment of how well medical science can intervene to prevent a specific disease. For diseases which are both significant and preventable, any type of intervention which is feasible in terms of specificity, sensitivity, risk, cost of the procedure and acceptance by the individual should be included as part of the health maintenance program.

A health maintenance program must be founded on a knowledge of the natural history of disease. The stages of disease have been classified as: (1) no risk, (2), at risk, (3) presymptomatic changes, (4) early symptoms, (5) frank symptoms, (6) disabling illness, and (7) dying. The first corollary to this hypothesis is that for the purposes of health promotion, the earlier in the progression of the disease that our intervention can take place, the better. The second corollary is that since in the very earliest stages of "no risk" and "at risk" one of the few ways that we can intervene is to educate people with regard to certain risk factors. Individual health education is an important modality to be applied. A health promotion program must employ several modalities of prevention which will differ according to the stage of progression of disease at which the intervention is directed.

Another important concept which must be addressed in designing a health maintenance program is that of periodicity. The periodic intervals of retesting for a specific illness should reflect the rate of progression of that illness. For example, a disease whose progression spans a decade such as carcinoma of the cervix, may require retesting every two years. Another illness such as preeclampsia which develops very rapidly during pregnancy may require retesting weekly or even more frequently. An attempt must be made to group diseases according to their rates of progression and to schedule different types of tests and examinations at sensible intervals. Still, the convenience factor cannot be ignored. Those diseases which are best screened for by physical examination need to be synchronized so that the necessary portions of the physical examination can be performed at one visit. Likewise other means of testing need to be overlapped so that the number of health promotion visits is reduced and cost benefits of some laboratory panels are afforded. Intervals of screening, however, can't follow purely chronological guidelines because some life changes such as changes in the family life cycle or changes occurring in an individual passing through developmental stages often bring life stresses which should be addressed as they occur.

The designing of a health promotion program must remain rather flexible. The state of the art doesn't justify being locked into a rigid system

"It must be recognized that health promotion is the responsibility of not only the health-care system but also other institutions which influence our lives. If programs are going to be truly comprehensive, all of these institutions must complement one another in their efforts for health promotion."

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which portends to be "the only right way." Secondly, it must be recognized that persons have individual risk factors, biases and preferences which may determine that for a particular person, a mammogram or thermography coupled by physician's examination is a more acceptable screening method than breast self-examination. Similarly, the person with a strong family history of diabetes and who has recurrent Candida infections may require more frequent screening for diabetes than the general population. This often will be justified even though it is determined by professional *intuition* rather than by a set of rigid criteria. Not only do people have individual differences but also practitioners themselves have biases based on their experience and training. Ample leeway must be permitted for these differences within the definitions of good health care. For example, whether one screens for anemia with a hemoglobin or a hematocrit and whether one screens for renal problems with blood urea nitrogen or creatinine makes little difference at the present stage of development.

A health promotion program must address not only illnesses which cause significant mortality but also illnesses which cause morbidity in terms of pain, suffering, time off work, and other factors. Many approaches to health promotion which are being promoted around the country are based solely on consideration of mortality statistics.

Finally, when developing these programs, it must be recognized that health promotion is the responsibility of not only the health care system but also other institutions which influence our lives. If programs are going to be truly comprehensive, all of these institutions must complement one another in their efforts for health promotion.

A major point of disagreement among health planners with regard to health maintenance programs is "who is responsible." Opinions vary from the extreme view that health promotion is not the affair of the physician but rather a personal responsibility, to the other extreme which argues that since the people have not taken responsibility for their own health it must be provided by primary care physicians or by public institutions. The fact is that society has already delegated responsibility for various areas of health maintenance.

A. INDIVIDUAL RESPONSIBILITY

There are some areas in which the individual has to assume primary responsibility for his or her own health or in the case of a young person, the parent must take responsibility for the child.

One of these is diet. Although diet plays a role in maintaining health, scientific data are lacking with regard to long-term effects of roughage, fats, vitamin supplements, refined carbohydrates, and the like. Reliable data are available to support the role of fluoride supplement in maintaining dental health, and that of certain vitamins and minerals in preventing deficiency states, but for the most part persons must determine for themselves what type of diet they will maintain. A related topic, weight control, has to do not only with the types of food selected but also the quantities of food prepared, served, and eaten. This remains very much a self-controlled and self-responsibility issue.

With regard to cardiac health, a person must assume his or her own responsibility for expanding and maintaining his or her cardiac reserve. Most experts agree this can be done through a vigorous exercise program. The type of program can assume many forms but basically requires that an individual spend twenty minutes three times a week in vigorous exercise which places a stress on the cardiovascular system. Certainly for people who are out of condition and wish to start an exercise program, they also have responsibility for asking a physician how to do this safely.

There is a long list of safety precautions that a person should know well. These would include decreasing hazards at home, driver's education, occupational safety, auto safety and seat belts, first-aid knowledge, child proofing the home, poison control and medicine storage. A person also should have some knowledge of basic medical care. He or she should learn the signs of possible cancer which are readily available through the public media, take responsibility for reporting symptoms when they appear, follow instructions given by a physician, and attain a knowledge of access to medical care. An individual has a responsibility to maintain up-to-date immunizations, to obtain prenatal and well-child care, to learn self examination of the breast, skin and

testes, and to complete periodic medical history and physical examination. The patient should attain a knowledge of basic dental care including the need for an annual examination and proper dental hygiene.

Each person is responsible for his or her own smoking habits and drinking habits, for knowing minimal first aid and perhaps expanding this to include knowledge of cardiopulmonary resuscitation and basic home medical care. One should assume personal responsibility for knowing basic skills such as swimming, driving a car, snowmobiling or being skillful at any of a number of potentially dangerous hobbies. Everyone should learn basic contraception information.

Finally, a person should be responsible for doing what he or she can to reduce stress in life and supplementing his or her life by adding life-enhancing activities. What will enhance one's satisfaction and happiness is an individual decision. It may be participation in athletics, developing a new hobby, immersing one's self in religion or practicing transcendental meditation. It should not be necessary to feel guilty about indulging one's self in pleasure activities, rather this should be recognized as a necessary part of maintaining health.

Areas of responsibility: "The individual has to assume primary responsibility for his or her own health . . . medical personnel . . . providing a periodic health assessment questionnaire or medical history . . . other support systems . . . protecting the emotional health of the individual . . ."

B. PHYSICIAN RESPONSIBILITY

A second area of responsibility is that filled by medical personnel, including not only physicians but also nurses and paramedical assistants. The first responsibility in the program to be proposed is that of providing a periodic health assessment questionnaire or medical history. Questions for this questionnaire will be selected to reveal early symptoms of significant preventable diseases and will focus not only on symptoms of established disease but also problems which serve as risk factors for potential disease. The purpose of the history should be explained to each person, with the understanding that this historical information is sometimes even more important than physical examination or laboratory studies. The test taking itself should be an educational experience, teaching the individual what symptoms the physician thinks are important and the significance of the question asked. For example, few patients will relate swollen ankles to possible congestive heart failure unless the question is worded so that the connection can be made by a person who does not have formal medical training.

The physical examination has always been the bailiwick of the physician. However, numerous types of physician extenders and paramedical personnel have been trained to do essential parts of physical examination. The physical examination should not be the complete head to toes physical which is taught to medical students and perpetuated by rote examinations for the completion of insurance forms, athletic physicals, and hospital admission summaries. The physical examination necessary for health maintenance consists of only a few selected basic signs which are significant in detecting preventable diseases in their earliest possible stages. Although the diseases being screened for do not necessarily progress at the same rate, the physical examination for the most part will be fairly standardized simply because this is the only way for the practitioner to be efficient and it saves numerous trips and numerous office appointments for the individual. In addition to this standardized health screening examination which is somewhat tailored to various age groups, each person should have a symptom-directed examination for any positive findings which were apparent on the health assessment questionnaire.

Other services offered by physicians would include providing access to laboratory studies and special tests, including developmental screening and psychometric screening when necessary. Immunizations can be provided through the physician's office as well as through free clinics and community organizations. The physician also should provide risk assessment services for those patients who are interested. The Health Hazard Appraisal[2] is a model to be followed.

Individual motivation can be influenced by the physician. If the physician recognizes he or she has an important product to sell, he or she should exercise some degree of "salesmanship" in trying to convince the individual to comply. The Health Hazard Appraisal system also provides a built-in motivation system for certain patients.

The physician naturally takes responsibility for the treatment of established disease, but this occurs much too late in the progression of disease to be desirable as the only phase of health promotion offered.

Finally, the physician is obligated to provide some sort of recall system to remind participants when their health promotion procedures, physical examinations and health questionnaires are due. This can be managed either by a manual tickler file or for clinics which have computerized billing

systems, an optional patient reminder message can often be sent along with other billing messages.

C. COMMUNITY RESPONSIBILITY

Another area of responsibility is assumed in our society by the patient's other support systems including counselors, clergy, and sometimes physicians. These aim at protecting the emotional health of the individual by providing support through life's predictable crises or passages and also intervention at the time when random crises occur. These support systems help an individual maintain emotional balance while making the transition through various phases of the family life cycle and various maturational phases of adult life.

The local community or its governmental equivalent on state and national levels also assumes some responsibility for promoting the health of the population by taking responsibility for safety and product regulation, firearms regulation, sanitation, and pollution control. The public has taken responsibility for basic financial support of individuals through welfare systems. They sometimes provide immunization clinics, screening clinics, and safe recreational facilities to enhance the life style of the citizenry.

The public schools assume responsibility for health education. This would include sex education and general knowledge of health matters. The schools also have undertaken some mandatory screening programs aimed at early detection of certain conditions. Recent legislation in Wisconsin has made the schools responsible for the checkpoint immunization enforcement which assures that all children entering school at any point are fully immunized. Through athletic programs and supervision of athletic activities, the schools to some extent encourage exercise and athletic safety. Physical education in the schools is directed at stimulating physical activity and fitness among our young people. (Unfortunately these programs often fail to meet these goals and would do better to stimulate interest in life-long forms of vigorous activity rather than emphasizing organized sports and rules for an endless variety of games.)

Industry has been an important economic factor in our society and also has begun to assume responsibility for the health of employees by complying with safety standards directed by governmental agencies such as OSHA—the Occupational Safety and Health Act. Industries provide insurance programs to help their employees obtain access to medical care. Frequently they require physical examinations, which may be preemployment or periodic in nature, and they sometimes have organized health maintenance programs. Recently several have begun to experiment with health promotion projects such as providing exercise programs, athletic facilities, and programs for treatment and prevention of alcoholism.

By no means least important, is the institution of the family in providing a central focus for health promotion. The diet selected by the family tends to be fairly standardized throughout that family. In the family, education is provided especially with regard to safety and sex education. (Too often, however, this educational function is more of an ideal than a norm.) It is in the family where life styles are developed which may emphasize or deemphasize the importance of physical activity, diet and attitudes about pleasure-seeking activities and life-enhancement activities.

PART 2 will appear in the December issue. ■

SOCIETY MOUNTS INFORMATION CAMPAIGN ON FAS

The State Medical Society launched a public information campaign in October to alert women of the potential dangers alcohol can have on their unborn children. Physician spokespersons in five major media centers in the state made themselves available to the news media to discuss the problem of fetal alcohol syndrome (FAS) in Wisconsin. It is estimated that as many as 3,000 women in Wisconsin will bear infants with symptoms of FAS this year. The program thus far has been quite successful with several physicians being contacted for radio and television news interviews, call-in shows, public affairs programs and newspaper interviews. The SMS Communications Dept is complementing this media effort by distributing a brochure, "Alcohol and Your Unborn Baby," which discusses the problem of Fetal Alcohol Syndrome, through physicians' offices, alcohol and other drug abuse agencies, SMS Auxiliary, legislators, and other groups. The brochure is available in large quantities by contacting the SMS Communications Dept in Madison.

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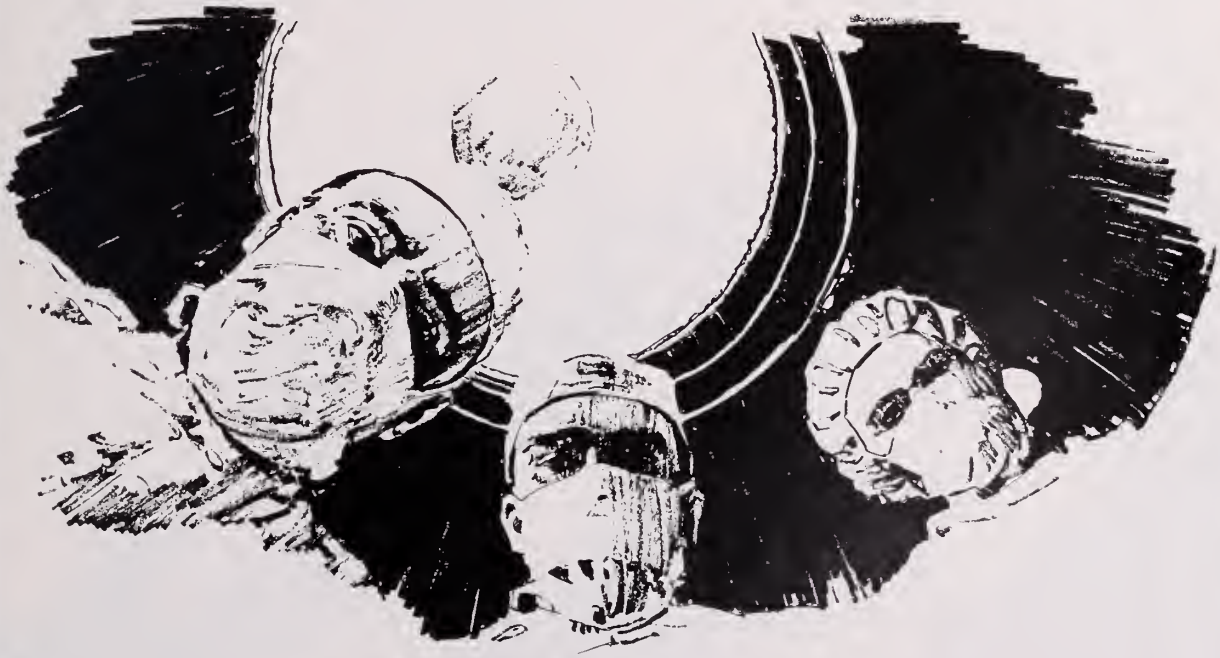

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Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Cancer epidemiology—Part V

Stomach cancer

STOMACH CANCER incidence has decreased in the United States by more than 50% in 25 years.[1] The reason is not known but may be related to our rising standard of living. Males are afflicted about twice as often as females. Internationally incidence varies, with the highest rates in Japan, Chile, Finland, and Iceland—countries bordering the ocean. This malignancy is of particular interest to Wisconsin physicians because the northern part of the state is in a band running through northern Minnesota, Wisconsin, and Michigan that has the highest mortality rate for this tumor in the US.[2-4]

Mortality figures for migrants tend to parallel those of the country of origin, suggesting that dietary factors may be the etiologic agents. White rice, fried foods, cabbage, smoked fish, broiled meats, soybeans, starches, heavy alcohol consumption, irregular eating habits, and laxatives have all been suggested as possible agents,[5-7] but no clear-cut link has been proven. In Japan contamination of talc-polished rice with asbestos-like fibers may be a factor in their excessive mortality rate. Nitrosamines, a class of potent carcinogens, may also be causative factors. Ingestion of nitrosamine precursors such as alkyl ureas, alkyl guanidines, and nitrites could result in intragastric formation of nitrosamines. Dimethyl and diethyl nitrosamines have been found in salt-dried fish prepared without being gutted. Fish is a major dietary item in all countries with high incidence rates.[8]

Pernicious anemia is associated with an increased risk of gastric cancer; this may be related to the accompanying atrophic gastritis. Vitiligo, immunodeficiency disorders, and previous operations for benign gastric lesions also have been associated with increased risk. There is a negative correlation between stomach cancer and cancer of the colon. People with blood group A have a 20% greater risk of stomach cancer.[9-12]

There may be a relationship between the use of coal and stomach cancer incidence. The decline in stomach cancer in the US has paralleled the decrease in home coal use. Stomach cancer is three times more common in coal miners than the general public. A benzopyrene derivative in coal may be the carcinogen. Weavers, farmers, and rubber and asbestos workers also have an increased risk.[13-14]

Cancer of the large intestine and rectum

Colo-rectal cancers account for about 15% of all malignancies. Except for common skin cancer, colo-rectal cancer will tie with lung cancer for the greatest number of new cancer cases diagnosed in 1978. Almost two-thirds of these patients could be saved if the disease were detected early and treated promptly. The 5-year survival for colon cancer is 46% and for rectal cancer is 44%. These mortality rates have changed little in the past 40 years.[15] Although there are unique features for each disease, the factors presented here will be common to both.

A major demographic feature of colo-rectal cancer is its wide variation in geographical incidence. The US and other Western countries have a much higher incidence than Japan or the developing countries. Migrants who move from low to high risk areas develop a risk approaching that of the country of adoption.[16] The sex ratio in the US is about equal. Incidence increases with age. Whites are more prone to this disease than blacks. In Wisconsin mortality in males is significantly higher than the national average in Milwaukee, Jefferson, Manitowoc, and Sheboygan counties. For females, Manitowoc, Oconto, Shawano, and Menominee counties have the highest mortality rates.[17]

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1978 by the State Medical Society of Wisconsin.

Dietary factors may be associated with colo-rectal cancer. Countries with a low incidence have more carbohydrates in their diet; high incidence is associated with a low bulk, high fat, high meat diet.[18] In the US, colon cancer is less common among those blacks whose major caloric intake is carbohydrate and Seventh Day Adventists who eat less meat and fat.[19]

Carcinogens may enter the colon directly via ingestion or arise in the colon from bacterial action. The low incidence of cancer of the small intestine supports the hypothesis that the agent responsible for colon cancer arises in the large intestine.[20] A high fat diet may affect intestinal bacteria so that they produce carcinogens. Bile acids, neutral sterols, digestive enzymes, amino acids, and fatty acids are all modified by intestinal bacteria. Several bile acids, including deoxycholic acid, bis-non-5-cholenic acid, and apocholic acid induce sarcomas when injected into experimental animals.[21] A correlation between death rate from colon cancer and fecal degradation and excretion of cholesterol and bile acid metabolites has been demonstrated.[20,22] People consuming a mixed Western diet who have a high incidence of colon cancer degrade and excrete more cholesterol and bile acid metabolites than populations with a low incidence of colo-rectal cancer.[22,23] Studies in the US looking for differences in meat consumption between people with and without colon cancer failed to detect a significant difference.

Colon cancer incidence may be related to dietary fiber, which affects fecal transit time.[24] Countries with high fiber diets have a low incidence of colo-rectal cancer, suggesting that lack of fiber in Western diets may account for increased incidence of this cancer. Burkitt[24,25] has implied that removal of dietary fiber which regulates speed of transit, bulk, and consistency of stools may be a causative factor and suggested that abnormal bacterial flora held for a long time in concentrated form may be carcinogenic. However, Wynder[18] could show no correlation between either constipation or serum cholesterol levels and colo-rectal cancer, suggesting that transit time is not important.

Adenomatosis polyps, ulcerative colitis, Crohn's disease, familial polyposis, diverticulitis, Gardner's syndrome, Peutz-Jeghers syndrome, hemorrhoids, appendicitis, diabetes, high blood pressure, atherosclerosis, coronary disease, and intestinal parasites have been associated with colo-rectal cancer.[24-26] Colon cancer patients who have had a uretero-sigmoidostomy[27] are one or two decades younger than usual for patients with this disease; the tumor frequently forms at the exact site of the ureteral entrance into the colon. Patients with a family history of colo-rectal cancer have three times the chance of developing this disease.[28] Insulation and shop workers exposed to asbestos, those who manufacture footwear, machinists, job setters, wood processors, and farmers are also at higher risk.[29] Colon cancer is negatively correlated with cancer of the stomach and positively correlated with cancer of the pancreas, kidney, breast, and prostate.[30-31]

(To be concluded)

(References may be obtained upon request to WCCC)

—Jane Harberg
Dorothy J Buchanan-Davidson, PhD

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Organizational SMS

SMS Services, Inc formed by Council

At its meeting October 28, the SMS Council approved Articles of Incorporation and Bylaws for SMS Services, Inc, a "for-profit" corporation which will serve a two-fold purpose of expanding services to members and generating additional and new sources of revenue to provide support for SMS programs and help offset the effects of inflation.

The corporation is authorized to undertake such activities as printing, insurance benefit programs for members, tours, practice management seminars, sponsored programs such as billing or collection services, and possibly, in the future, computer services or a professional liability program.

The formation of the for-profit corporation was authorized by the SMS House of Delegates on April 14, 1978 if the Council "felt this was advisable."

The Council elected the following MDs to the Board of Directors of SMS Services, Inc: For one-year terms, Timothy T Flaherty, Neenah; Russell F Lewis, Marshfield; and Duane W Taebel, LaCrosse. For two-year terms, Paul G LaBissoniere, Wauwatosa; William P Crowley Jr, Madison; and Allen O Tuftee, Beloit. For three-year terms, Daniel K Schmidt and John P Mullooly, Milwaukee. Society secretary and general manager, Earl R Thayer, Madison, also was elected for a three-year term.

Other Council action

In other action at its October 28 meeting the Council:

• Approved a series of recommendations by the Ad Hoc Committee on Quality Care Activities which include:

1) Giving the Commission on Mediation and Professional Ethics and the Commission on Peer Review full authority to take disciplinary action on problem physicians. This action would include education and rehabilitation requirements, reprimands, or referral to the Medical Examining Board. The physician under review would have the right to appeal these actions to the Council.

2) The Impaired Physician Program will remain the responsibility of the Commission on Mediation and Professional Ethics. A panel of physicians who have overcome alcohol and drug related problems will be established to work with physicians who are identified as impaired.

3) The process for receiving and reviewing patient or other complaints against physicians by the Commission on Peer Review, the Commission on Mediation and Professional Ethics, and the Impaired Physician Program should be better publicized.

4) Directed the immediate updating of due process protocols to assure patient and physician rights in Society handling of complaints.

• Directed SMS staff, through the Commission on Health Planning, to prepare a report on the status of Health Maintenance Organizations and Independent Practice Associations (HMOs/IPAs) in Wisconsin and develop a series of principles for guidance to SMS members.

• Authorized each Commission and Committee of the State Medical Society to add a resident physician member in a voting capacity.

• Met with Arnold L Brown, MD, dean of the University of Wisconsin Medical School, to discuss issues of concern to both academic and privately practicing physicians.

• Heard recommendations regarding the practice patterns of two physicians. The Council directed that one physician be referred to the Medical Examining Board for investigation; the other's practice is to be monitored on a continuing basis with report back to the Council.

• Appointed Gerald C Kempthorne, MD, Spring Green, to fill the vacancy on the Council of Richard Edwards, MD, Richland Center, who has resigned to serve as an Alternate Delegate to the American Medical Association effective January 1, 1979.

• Appointed Pauline M Jackson, MD, LaCrosse, to fill the vacancy of Cornelius Natoli, MD, LaCrosse, who is also resigning to serve as an AMA Alternate Delegate in January 1979. ■

Reminder on CME credits

Physicians are reminded to send their documentation for Category I CME credit to the State Medical Examining Board, 1400 East Washington Ave, Madison, Wis 53703.

Physicians are not to send this information to the State Medical Society.

The ME Board suggests that physicians send their credits of Category I hours as they accumulate them. *If by the Fall of 1979, a physician has not submitted documentation for any Category I credits, s/he will not be sent a notice for renewal of licensure.* ■

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State liability plan to expand coverage offering

The Board of Governors of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) has voted to provide coverage to allied health personnel who are under the employ of a physician (*eg*, physician's assistant). Rates for such coverage have not yet been determined.

In other action, the Board decided to form a committee to investigate loss prevention mechanisms for the State Plan. Presently, the Plan has no such mechanism. The Board also is continuing its appeal to the Internal Revenue Service to obtain tax-exempt status for the Plan. The IRS has said that the Plan is not tax exempt, because even though it is an instrument of state government, the Plan is in competition with the private insurance industry.

As of June 30, 1978, the Plan reports that it has over $31 million in current assets and a net investment income in excess of one million dollars for the first six months of 1978.

About 3,000 physicians, surgeons, and osteopaths have taken out policies in the Plan since its inception in 1975. During this period, $21,960,265 has been received in written premiums, of which $18,950,238 is earned premiums. Since 1975, $602,537 has been paid out in losses for 32 claims against physicians, surgeons, and osteopaths; and $1,243,500 has been reserved for 109 known but unpaid claims. More than 15.5 million dollars is reserved for possible claims (incurred but not reported). More than $270,000 is attributed to expenses incurred in processing cases (*eg*, attorney fees, bringing in expert witnesses, etc). ■

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Environmental Health Committee studies smoking, wastes

The SMS Environmental Health Committee began studying a proposal which would impact on where persons could smoke in publicly owned places at its October 11 meeting. At that meeting, Rep Mary Lou Munts was present to discuss her bill which would require owners to designate smoking and nonsmoking areas in their buildings. The Committee is considering endorsing the bill and will make its final recommendation to the Commission on Governmental Affairs later this fall.

Rep Tom Loftus also will be meeting with the Committee this fall to discuss the issue of hazardous waste substances and their effect on the public health.

During the last few months, the Committee has been seeking out individual environmental problems statewide for study and possible legislative action.

The Environmental Health Committee currently has a vacancy, and anyone interested in these ecologic issues and willing to serve on this committee is invited to contact its chairman, Wendelin W Schaefer, MD, in care of the Physicians Alliance Division at SMS headquarters in Madison; phone toll-free: 1-800-362-9080. ■

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COUNCIL MINUTES

STATE MEDICAL SOCIETY OF WISCONSIN

August 5, 1978—Madison

1. Call to Order and Roll Call

The meeting was called to order by Chairman Haskins at 11:10 AM on Saturday, August 5, 1978, at the State Medical Society.

Voting members present: Chairman Haskins; Vice-chairman Flaherty; Doctors LaBissoniere, Mullooly, Eisenberg, Bruhn (PM), Foley, Boulanger, Schmidt, Steffen, Edwards, Waterhouse, Crowley, Natoli, Kief, Lewis, Barrette, Levin, Treffert, Motzel, and Taebel.

Others present: Doctors Lubitz, Viste, Nordby, Derus, Scott, Williamson, Stuff; Messrs Thayer, Maroney, Jensen, Nelson, LaBissoniere, Neuberger, Brozek, Mendelson, Jacobson, Bevan, Wood, Brown, Murphy; Mmes Bartel, Upton; Miss Pyre.

2. Approval of Minutes of June 3, 1978

There being no additions or corrections, the chairman declared the minutes approved as distributed.

3. Governmental Affairs Commission

Doctor Lubitz reported studies of the GAC and its ad hoc committees relative to a state catastrophic health insurance plan, legislative definition of death, creation of an independent Department of Health, and problems with implementation of the law on testing of infants for metabolic disorders and the state laboratory certification program. He reported also that the Commission will undertake a study on the implications of chiropractors seeking laboratory certification and what they are permitted to do under the law. The Council advised that authority should be requested later in event of need for outside legal counsel or action.

4. Physicians Alliance Commission

Doctor Viste and Mr Jensen presented status reports on all aspects of the Title 19 contract and related matters. They pointed out that it will take time after the Legislature convenes in January to secure passage of legislation to eliminate the requirement of a provider contract, possibly necessitating another interim contract related to "Super Rule."

Doctor Flaherty objected to the EDS announcement that after January 1, 1979, it would accept only the uniform claim form. On motion of Doctors Flaherty-Mullooly, carried, the Council directed that DHSS and EDS be informed that the January 1 deadline for the mandatory use of the uniform claim form is unacceptable and unrealistic, and should be delayed at least until July 1, 1979, to give time for orderly implementation in a physician's practice.

Doctor Nordby, who has accepted membership on the Medical Liability Committee of the PAC, presented a proposal being considered by WHCLIP for a claims review and risk management program operated by Medical Liability Consultants of Colorado. He indicated that the board of governors would likely make a decision before the next Council meeting on a pilot program for risk management, and recommended that the Council support the general proposition and authorize the PAC committee to act in negotiations on a program for Wisconsin.

On motion of Doctors Lewis-Kief, carried, the recommendation was approved.

5. State Health Plan

Councilors had received the recommendations from all sections of the State Health Plan which are to be submitted for Health Policy Council approval on August 24-25. Staff noted that many of these had been redrafted following public hearings with advice from specialty respresentatives who were generally satisfied with improvements that had been made.

Mr Thayer called attention to the scope and implications of proposed continuing education requirements in connection with the use of diagnostic X-ray (radiology section of proposed State Health Plan).

On motion of Doctors Kief-Edwards, carried, the Council requested that an alternative approach be developed with radiology to the concern of limiting population exposure to ionizing radiation, which was believed to be the intent of the section in question.

6. Wisconsin Review Foundation

Doctor LaBissoniere presented the report and recommendations of the Interim Steering Committee on Peer Review which had been mailed to the Council a month earlier. After general review of the purposes and discussion of the effects on WisPRO, the Council adopted a series of resolutions as follows:

A. Creation and Support

On motion of Doctors LaBissoniere-Waterhouse, carried, the following resolution was adopted:

Resolved, That the Council, in response to the House of Delegates action of April 15, 1978, relative to peer review, take immediate and appropriate steps to create and support a statewide, nonmembership organization for peer review of medical care to be known as the "Wisconsin Review Foundation," and that the initial activity of the Wisconsin Review Foundation focus on private patient and non-mandated peer review.

B. Board of Directors

On motion of Doctors LaBissoniere-Eisenberg, carried, the following resolution was adopted:

Resolved, That the Council declare its intent to appoint the original and subsequent membership of the Board of Directors of Wisconsin Review Foundation; and

That the initial Board of Directors be appointed in such a manner as to achieve "the appropriate relationships with state organized medicine" as required by the House of Delegates action of April 15, 1978, and that this be accomplished as follows:

a. A Board of Directors of 25 in total number

b. Composition of the Board as follows:

- 14 physicians, including 1 each from nominations submitted by WisPRO, FMCE, and Wisconsin Association of Osteopathic Physicians & Surgeons
- 1 Secretary of the State Medical Society of Wisconsin
- 3 persons representing hospitals from nominations submitted by the Wisconsin Hospital Association
- 3 persons representing the "Blue Plans" in Wisconsin (1 each from nominations submitted by Blue Cross, Surgical Care, and WPS)
- 2 persons representing private insurance carriers in Wisconsin (from nominations submitted by the Wisconsin Health Insurance Council)
- 1 person representing Wisconsin business/industry
- 1 person representing Wisconsin labor

c. The slate of nominees to be developed by the Nominating Committee of the Council

d. Terms to be three years, staggered

In response to question, Doctor Haskins said it was the intent of the Nominating Committee of the Council to accept the nominations from organizations outside the Society so that in effect they will be appointing their representatives on the Board.

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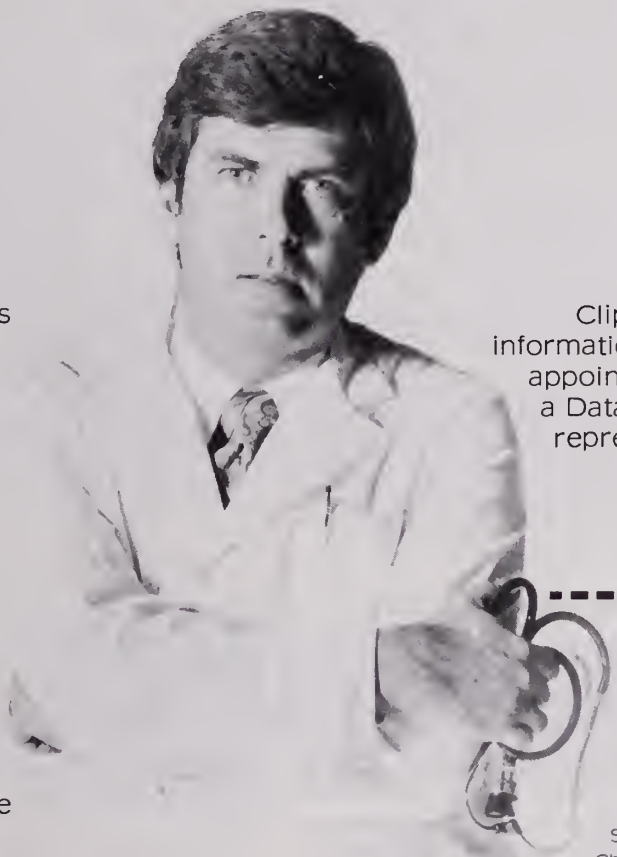

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C. Funding

On motion of Doctors LaBissoniere-Crowley, carried, the following resolution was adopted:

Resolved, That the $5,000 contribution of the State Medical Society to the start-up, first year funding of Wisconsin Review Foundation, as authorized by the Council on June 3, 1978, be contingent upon shared funding by the Wisconsin Hospital Association, the Blue Plans (Blue Cross-Surgical Care-WPS), and the private insurance carriers, and failing full first year funding participation as allocated by all parties, only those whose contribution has been received by December 1, 1978, shall be eligible for Board or committee representation; and

That accounting for the costs of Wisconsin Review Foundation development shall begin immediately, not to include in-kind services of SMS and other organizations, but including the costs of the consultant for the May 18, 1978, meeting of the Interim Steering Committee and legal fees associated with the development of proposed articles and bylaws, the original bylaws being subject to the approval of the Council.

D. Reporting

On motion of Doctors LaBissoniere-Barrette, amended by Doctors Lewis-Eisenberg, this resolution was adopted as follows:

Resolved, That the Council of the State Medical Society expects and requires the Board of Directors of Wisconsin Review Foundation to report to it annually or more often, as well as to the other interests represented on the Board, and that the Board develop direct linkages with the State Medical Society to facilitate effective educational, disciplinary, and other related activities.

E. Goals and Objectives

On motion of Doctors LaBissoniere-Mullooly, amended by Doctors Motzel-Edwards, this resolution was adopted as follows:

Resolved, That the Council of the State Medical Society intends and expects that the initial peer review goals and objectives of Wisconsin Review Foundation be those set forth by the Interim Steering Committee (attached to original minutes); and

That, while concurrent review (such as utilization review involving admission certification and initial/continuing length of stay) is an important segment of overall medical care review, the Council of the State Medical Society expects the primary emphasis of Wisconsin Review Foundation to be quality assessment through but not limited to medical audit and profile analysis (retrospective quality studies related to process and/or outcome of treatment); and

That confidentiality of patient, physician, hospital and carrier information is critical to continued support of a peer review effort and therefore requires the development of strict confidentiality policies by the Board of Directors of Wisconsin Review Foundation.

F. Relationships with PSROs

On motion of Doctors LaBissoniere-Edwards, carried, the following resolution was adopted:

Resolved, That it is the intent of the Council of the State Medical Society that, once established, the Board of Directors of Wisconsin Review Foundation will function autonomously; and

That Wisconsin Review Foundation will provide the policy and administrative direction required for its programs of peer review, and will as needed develop agreements to utilize the services of FMCE and WisPRO for certain operational functions and in other ways seek to work cooperatively with FMCE and WisPRO to coordinate peer review efforts in Wisconsin, both private and government mandated, always keeping in mind and working toward the "ideal organization" established as a goal by the House of Delegates on April 15, 1978.

G. Transfer of WisPRO from WHCRI

On motion of Doctors LaBissoniere-Mullooly, carried, the following resolution was adopted:

Resolved, That, consistent with paragraph 7 and the general intent of the House of Delegates Resolution on Peer Review adopted April 15, 1978, the Council of the State Medical Society requests that the Wisconsin Review Foundation and WisPRO take such immediate steps as are necessary to as soon as possible separate the latter from WHCRI and transfer its componency to Wisconsin Review Foundation.

Doctor Haskins then presented the report of the Nominating Committee with recommendations for 20 of the 25 positions on the initial Board of Directors of Wisconsin Review Foundation. Nominations had not yet been made by FMCE, WisPRO, WPS, the osteopathic association or labor.

By various motions made, seconded and carried, the following were elected to the Board pursuant to resolution B above:

Antoine Barrette, MD, Peshtigo
Thomas J Doyle Jr, MD, Eau Claire
Paul G LaBissoniere, MD, Wauwatosa
Rocco Latorraca, MD, Wauwatosa
Jules D Levin, MD, Milwaukee
Johan A Mathison, MD, Oshkosh
Richard C O'Connor, MD, Wausau
John D Riesch, MD, Menomonee Falls
William Rock, MD, Madison
Robert A Starr, MD, Viroqua
Blake E Waterhouse, MD, Madison
Earl R Thayer, Madison
Kenneth VanBree, Divine Savior Hospital, Portage
Donald Orleans, Holy Family Hospital, Manitowoc
Karl York, St Luke's Hospital, Racine
Robert C Haskins, Blue Cross of Wisconsin, Milwaukee
Thomas H Girard, Surgical Care Blue Shield, Milwaukee
Lloyd F Mathwick, Employers Insurance, Wausau
Roger R Rheeling, Rural Insurance, Madison
John W Matheus, Allen-Bradley, Milwaukee

7. Report of Executive Committee

A. UW Family Practice Program

Doctor Levin presented a proposed resolution and moved its adoption; seconded by Doctor Barrette. Doctors Motzel-Schmidt moved for division of the question and separate action on each of the three proposed resolves; carried. The resulting resolution is quoted as follows:

WHEREAS, The State Medical Society of Wisconsin, an organization which represents over 4,500 physicians in the State of Wisconsin, has for more than a decade strongly supported the creation and viable continuation of a Family Practice residency program in this state; and

WHEREAS, The Society, in cooperation with the Wisconsin Academy of Family Physicians and interested consumers, has spent thousands of voluntary hours in demonstrating the need for the program at the University of Wisconsin in order to train new family physicians who can be of service to all citizens; and

WHEREAS, The Legislature, through this support and the insight it gained from the people it represents, created

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funding for the University of Wisconsin Family Practice Program so that individuals who would contribute to the quality and continuation of community-based health care, including hospitals, could be adequately trained; and

WHEREAS, The organization of the program to date has provided it with the necessary ability to meet the needs and desires of Wisconsin citizens; therefore be it

Resolved, That the State Medical Society of Wisconsin continue its support of and interest in a strong Family Practice Program in order to assure that adequate hospital facilities and health care providers are available on a local level; and be it further

Resolved, That the Society recommends to the University of Wisconsin, and the Legislature if indicated, that the State Medical Society and the Wisconsin Academy of Family Physicians participate in any committee formed to review the program; and be it finally

Resolved, That the Society recommends the selection of a family practitioner to head the Department of Family Medicine and Practice of the University of Wisconsin Medical School.

B. Commission Appointments

On motion of Doctors Levin-Lewis, carried, James T. Houlihan, MD, Woodruff, was appointed to a vacancy on the Commission on Continuing Medical Education.

On motion of Doctors Levin-Mullooly, carried, the Council deferred consideration of an appointment to the Physicians Alliance Commission to succeed Doctor Jacobs who resigned.

C. Miscellaneous

Doctor Levin also reported for information on several routine matters considered by the committee, and its recommendations that (1) physicians wishing to participate in the Canadian Health Care Seminar in Toronto in November do so at their own expense, and (2) no Society funds be committed for a proposed mass purchase and distribution of plastic card immunization records for all preschool children in the state.

8. Committee on Economic Medicine

Doctor Schmidt reported the committee's concern as to legal and ethical implications of financial benefits accruing to the Society from certain endorsed programs for members such as the collection service. The committee was requested to review the entire matter and report back in relation to the proposed for-profit corporation, SMS Services, Inc., on which action was postponed.

He also reported the poor response to date on the scheduled practice management seminars; that seminars for residents were planned by the CPA and Bar Associations and the committee approved Society cosponsorship with no financial involvement; approval of a sponsored tour to Oberammergau in the fall of 1980; negotiation of a new hospital-surgical-medical program for SMS members with WPS; and plans for a more aggressive sales program to improve enrollment of younger physicians in Society insurance plans.

9. Finance Committee

Doctor Foley presented an informational status report on income and expenses at midyear which was accepted by the Council.

10. Commission on Health Planning

A. Statement on Interprofessional Relations—Physicians and Physical Therapists

On motion of Doctors Kief-Barrette, carried, the Council approved the statement developed by an ad hoc committee of the Commission and the Wisconsin Chapter, American Physical Therapy Association.

B. Specialty Representation

On motion of Doctors Natoli-Edwards, carried, the Council approved nominees of various specialty societies and sections for voting representation on the Commission on Health Planning provided they are Society members.

11. Commission on Public Information

On motion of Doctors Mullooly-Natoli, carried, the Council approved the content of a "Partners in Good Health" brochure to be made available to members for distribution to patients in their offices, statements, etc.

12. Resolution 36, 1978—Health Screening

This resolution, requesting investigation of the problem of the increasing proliferation of both private and public programs of diagnostic screening, treatment and health education, had been referred to the Task Force on Health Screening and Immunization, which has representation from the Department of Health and Social Services and the Department of Public Instruction as well as the Society.

On motion of Doctors Edwards-Mullooly, carried, the Council approved the following policy statement recommended by the Task Force, with emphasis on the last two paragraphs:

The State Medical Society of Wisconsin adopts as its definition of Health Screening the definition of the Ad Hoc Committee on Screening of the Health Policy Council adopted in January 1975. As modified by the Task Force on Health Screening and Immunization, the definition reads:

HEALTH SCREENING

(1) is an integral part of health care and
(2) a preventive health measure
(3) which results in the early detection of the risk of diseases or disability
(4) when applied in an undiagnosed population
(5) in conformance with the following criteria:
  (a) a relatively simple procedure which is safe, low in unit cost, can be performed in a brief span, and does not require the skills of a physician for its execution;
  (b) designed to identify one or more specific risk factors for disease or disability;
  (c) resulting in a division of the population into high-risk and low-risk groups;
  (d) and effective education, prevention, treatment or management modalities are accessible to the identified population.

It is felt that health screening programs which meet these criteria are of benefit when applied to large populations.

The State Medical Society of Wisconsin also recognizes the value of diagnostic tests widely applied by physicians on asymptomatic populations or individuals. These diagnostic tests are done for the purpose of health promotion or early detection of latent disease and are considered to be of value, so long as they comply with the following criteria:

1. The tests should be simple, although they may require a physician's skills or supervision for their execution.
2. The tests should be of proven cost effectiveness.
3. The tests should be acceptable in terms of safety, time, and patient acceptance.
4. The patient should be of sufficient specificity, sensitivity, and accuracy to make it valid.

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- **Western Metal Specialty Co**, 1211 N 62nd St, Milwaukee, WI 53213; 1-414/771-7700
- **The A Center of Racine** (an alcohol and other drug treatment facility), 2000 Domanik Dr, Racine, WI 53404; 1-414/632-6141
- **Matt Talbot Lodge Inc** (A Halfway House for Alcoholics), 2613 W North Ave, Milwaukee, WI 53205; 1-414/342-5474

In cooperation with

- **Wisconsin Assoc on Alcoholism and Other Drug Abuse, Inc**
- **State Bureau of Alcohol and Other Drug Abuse**
- **Wisconsin Clearinghouse for Alcohol and Other Drug Information**, PO Box 841, Madison, WI 53701

It should be noted that the nature of the test, the expense, and the physician involvement may make these tests inappropriate for health screening according to the above definition.

These screening tests and diagnostic tests should not be applied unless there is a consensus that the risk of the illness justifies the investment in the test in terms of costs, risk, and patient compliance.

13. Report of AMA Delegation

Doctor Derus reported highlights of the June AMA convention, including the election of Doctor Collentine to the Council on Medical Service.

14. "Planning and Implementing a Health Promotion Program"

Doctor Eisenberg reported that he had submitted Doctor Hankey's paper to representatives of several primary care specialties, and that certain additional examinations had been suggested by pediatrics.

On motion of Doctors Eisenberg-Edwards, carried, the paper was approved with the additions.

15. CES Foundation Nonmedical Trustees

On motion of Doctors Schmidt-Edwards, carried, the Council reelected Messrs George Becker, Fond du Lac; Donald DeWitt, Oconto; and Judge Kent C Houck, Richland Center.

On motion of Doctors Barrette-Levin, carried, the Council accepted a proposed nominee, pending his acceptance, to succeed James Morton Smith as a nonmedical trustee.

16. Future Meetings

On motion of Doctors Edwards-Schmidt, carried, the Council requested that its summer meeting (July or August) henceforth be scheduled on a week day.

The next Council meeting will be on Saturday, October 28, at 9:00 AM, with committee meetings on Friday, the 27th.

17. Adjournment

The meeting adjourned at 4:00 PM.

EARL R THAYER
Secretary

Approved Oct 28, 1978
PAUL S HASKINS, MD
Chairman

■

Remember to order UNIFORM CLAIM FORM

All SMS members in October received a letter detailing ordering instructions for the SMS/Clinic Managers-approved Uniform Claim Form. Use of the form is mandatory on Medicaid claims beginning Jan 1, 1979 and it also will be accepted by Medicare, Surgical Care, and WPS. It will not be accepted by CHAMPUS. The forms will be available from SMS about December 1 in two-part snapout or continuous pinfed form. For more information or for special price quotes on orders greater than 12,000, contact Lee Johnson at the SMS Administrative Services Division. ■

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

John F Frost, MD*

. . . Rhinelander, a member of the medical staff of the W S Bump Medical Group, recently completed all requirements for admission to and membership in the American College of Physicians. He has been a member of the Clinic since 1976.

Dennis M Bathke, MD

. . . LaCrosse, recently became associated with the Gundersen Clinic, Ltd in the Department of Anesthesiology. He graduated from the University of Wisconsin Medical School, Madison, and served his internship at Milton S Hershey Medical Center, Hershey, Pa. His residency was at the University of Pennsylvania, Philadelphia, where he also completed an anesthesia fellowship in 1977. Prior to joining the Clinic, Doctor Bathke had been an associate in anesthesia at Northwestern University Medical School in Chicago.

Russell E Holmes, MD*

. . . staff physician with the Mendota Mental Health Institute, Madison, has been appointed Commissioner of Health for Racine, replacing Gabriel P Ferrazzano, MD* who retired. Doctor Holmes served as a director with the Bureau of Health Facilities and Services, Division of Health, Madison, from 1973 - 1976. He graduated from the University of Wisconsin Medical School, Madison, and obtained a master's degree in public health administration from Yale University. His residency in preventive medicine was with the Division of Health, Madison, and he also has been an instructor at the University of Wisconsin Medical School in Madison.

William Ellwein, MD
John Pederson, MD*

. . . LaCrosse, recently joined the medical staff of St Francis Hospital. Doctor Ellwein is working with the St Francis emergency department. An internal medicine specialist, he graduated from the University of Minnesota Medical School and interned at Lutheran Hospital, LaCrosse. Doctor Pederson, a pathologist, is a 1972 graduate from the University of Wisconsin Medical School, Madison, and served his internship at St Mary's Hospital, Minneapolis, Minn. His residency was taken at University Hospital, Madison, where he was chief resident during his final year.

Singh Saini, MD

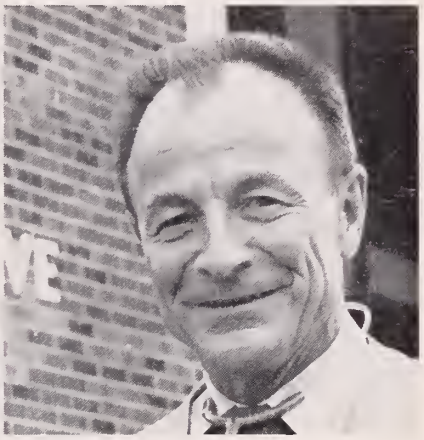
. . . recently joined the medical staff of the Tomah Veterans Administration Hospital. Doctor Saini will serve as chief of the Respiratory Care Unit. He graduated from medical college in India, and received three years of internal medicine training in New York and Chicago, and also served a two year residency course in pulmonary medicine in the United Kingdom. Prior to joining the medical staff at the VA hospital, Doctor Saini completed a fellowship at the University of Missouri in Columbia.

Clifford Simske, MD*

. . . Wauwatosa, recently was appointed a member of the active attending staff of Milwaukee Psychiatric Hospital. He completed residency at Cherokee Mental Health Institute, Cherokee, Ia, and also served for one year as unit chief of the Veterans Administration Hospital, Sheridan, Wy. Prior to joining the Milwaukee Psychiatric Hospital, Doctor Simske had been associated with the Eau Claire Clinic, Ltd.

David R Finch, MD*

. . . Appleton, recently opened his medical practice in the specialty of Plastic and Reconstructive Surgery. He graduated from West Virginia University Medical School and served his residency at the University of Wisconsin, Madison. Doctor Finch also is a member of the medical staff of Appleton Memorial Hospital, St Elizabeth Hospital, and Theda Clark Regional Medical Center.



Gerald Derus, MD*

. . . recently was featured in the *Monona Community Herald* newspaper column PEOPLE. Doctor Derus founded the Monona Grove Clinic just 25 years ago and has been active in the affairs of the Village of Monona. (*Community Herald* Photo)

Jeanne Diefenbach, MD

. . . recently joined the medical staff of Hudson Clinic, SC. She graduated from the University of Minnesota Medical School and served her internship at Northwestern Hospital in Minnesota. Doctor Diefenbach had previously been associated with the University of Minnesota Health services and the University of Minnesota Cancer Detection Clinic. For the past two years, she has been the medical director at the Hudson Hospital Convalescent Care Unit.

Robert Waffle, MD*

. . . Fond du Lac, recently received the "Physician of the Year Award" for "attention to the needs of the chronically ill and elderly residents in nursing homes that is above and beyond the call of duty." The award was presented in Stevens Point at the 27th annual convention of the Wisconsin Association of Nursing Homes.

Duane Amundsen, MD
Richard Fitzpatrick, DO

. . . recently joined the Skemp-Grandview medical staff of LaCrosse and West Salem. Doctor Amundsen graduated from the University of Minnesota, Minneapolis, and completed a residency in general surgery and a fellowship in peripheral vascular surgery at the Naval Regional Medical Center, San Diego. Prior to joining the Clinic, he headed the vascular surgery department at the National Naval Medical Center, Bethesda, Md. Doctor Amundsen who is associated with the Skemp-Grandview Clinic, West Salem, is a general practitioner and graduated from the Chicago College of Osteopathic Medicine. He completed a rotating internship at Milwaukee County, Milwaukee Childrens and Northwest General hospitals in Milwaukee.

Michael Feigal, MD
Charles Folkestad, MD
Jim Haemmerle, MD

. . . Menomonie, recently joined the medical staff of the Red Cedar Clinic. Doctor Feigal graduated from the University of Minnesota Medical School and completed his family practice residency at Bethesda Lutheran Medical Center, St Paul, Minn. Doctors Folkestad and Haemmerle also are graduates from the University of Minnesota Medical School and Doctor Folkestad served his residency at St John's Hospital in St Paul and Doctor Haemmerle completed an orthopedic residency at the Mayo Clinic in Rochester.

Dowe P Cupery, MD*

. . . recently was honored at a testimonial dinner by his co-workers, professional colleagues, and friends. Doctor Cupery, Markesan, one of the founders of the Waupun Memorial Hospital, recently retired from his medical practice.

Vicki Hastings, MD

. . . Hudson, recently joined the medical staff at St Croix Valley Family Practice. Doctor Hastings graduated from the University of Minnesota Medical School and completed her residency in Family Practice at Bethesda Lutheran Medical Center in St Paul, Minn.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1978

2 Dane County Physicians Alliance Committee
3 Dane County Medical Society Board of Trustees
3 SMS Auxiliary Bylaws Committee
4 Health Care Coalition
4 Ad Hoc Committee for an Independent Department of Health
9 Madison Society of OB-GYN
9 Dane County Physicians Alliance Committee
10 WISPAC Board
10 Dane County Medical Society General Membership
10 Wisconsin Society of Radiological Technologists with the Medical Examining Board
11 SMS Commission on Governmental Affairs
11 SMS Commission on Mediation and Professional Ethics
11 SMS Committee on Environmental Health
12 WisPRO Staff
13 WisPRO Staff
17 WisPRO Review Coordinator Conference
17 Cost Evaluation Committee
17 T19 Oversight Committee
18 Greater Madison Convention and Visitors Bureau
20 SMS Physicians Alliance Commission
24 Dane County Medical Society HMP Committee
25 Wisconsin Review Foundation
25 Wisconsin Review Foundation, Methodology Review Task Force
26 WisPRO Exit Conference
27 SMS Commission on Continuing Medical Education
27 Finance Committee of SMS Council
27 SMS Committee on Economic Medicine
27 *Executive Committee of SMS Council (Madison)*
27 WisPRO Continuing Medical Education Committee
28 SMS Council
28 AMA Delegation

Meetings not held in the Society "Home" but which have a direct relationship are printed in italic with the location in parenthesis.

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Roy Dunlap, MD

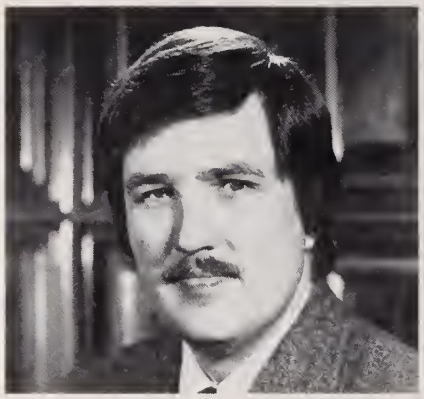
. . . recently opened his medical office in Stevens Point in the specialty of otolaryngology. He graduated from the University of Minnesota Medical School, interned at the University of Oregon Health Science Center, Portland, and then spent two years with the Indian Health Service in New Town, ND. Doctor Dunlap completed his residency at the University of Oregon.

Gail H Williams, MD*

. . . a general surgeon at the Marshfield Clinic, was recipient of the 1978 Annual National Divisional Award, American Cancer Society, for distinguished service in cancer control. The recognition came during the annual dinner of the ACS Wisconsin Division, October 20, in Oconomowoc.

Robert A Hyndiuk, MD*

. . . a Milwaukee eye physician, received the coveted Honor Award from the American Academy of Ophthalmology at the society's annual scientific meeting held in Kansas City, Mo. To qualify for the award, an ophthalmologist must provide years of distinguished service in any combination of media designated by the Academy for the continuing education of fellow ophthalmologists.



Dr Hyndiuk

Dr Dortzbach

Richard K Dortzbach, MD*

. . . Madison, recently received the coveted Honor Award from the American Academy of Ophthalmology at the society's annual scientific meeting held in Kansas City, Mo. Doctor Dortzbach is assistant clinical professor, Department of Ophthalmology, University of Wisconsin Medical School and University Hospitals, Madison. Since 1969, Doctor Dortzbach also has been an instructor of ophthalmic plastic surgery for The American Academy of Ophthalmology and Otolaryngology.

Treat yourself to a day, a weekend or an entire week!

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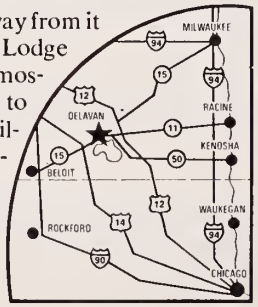

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'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. Blood: Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Gastrointestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

The Wisconsin Neurosurgery

. . . Society recently installed Hiro Nishioka, MD,* Green Bay as their president at the annual meeting held in LaCrosse. Other MDs elected to office were: William F Bingham, LaCrosse, president-elect; Ralph L Suechting,* Neenah, vice president; and Teofilo O Odulio,* Wausau, secretary-treasurer. ■

Milwaukee Medical Society

. . . will sponsor a two-day conference, "Milwaukee's Search for Health Care Cost Containment," on November 30-31 at Olympia Resort, Oconomowoc.

"The conference is designed to bring together those involved in all aspects of local health-care delivery to explore basic approaches to cost containment," said Shimpei Sakaguchi, MD,* president of the Society.

The conference will provide participants with a look at the cost containment issue from a variety of perspectives, including those of consumers, employers, educators, hospitals, and physicians.

Representatives of business, labor, hospitals, nursing homes, health-care agencies, the media, and the entire membership of thc Medical Society of Milwaukee County have been invited to the conference, Doctor Sakaguchi said.

Panels and workshops will cover such topics as "First Dollar Coverage" and "How to Make More Appropriate Use of Hospitals and Physicians."

Derward Lepley Jr, MD,* president-elcct of the Society, explained that local speakers would be used because they have a specific, rather than generalized, view of Milwaukee problems.

Mount Sinai Medical Center

. . . in Milwaukee sponsored its third annual symposium on nuclear cardiology, October 12-14, in collaboration with its Soref Heart Center.

Specialists in the field from throughout the country served as faculty for the program.

W Dudley Johnson, MD,* head of cardiovascular surgery at Mount Sinai and associate clinical professor of surgery in the Department of Thoracic Cardiovascular Surgery at the Medical College of Wisconsin in Milwaukee, was a member of the faculty.

Program chairman was Donald H Schmidt, MD,* who is Head of the Cardiovascular Disease Section at Mount Sinai. He also is Professor of Medicine on the faculty of the University of Wisconsin Medical School.

Cosponsoring the program were the Cardiovascular Life Sciences Program of the University of Wisconsin Medical School; the Department of Continuing Medical Education, Health Sciences Unit of the UW-Extension; the American Heart Association-Wisconsin Affiliate; and the Society of Nuclear Medicine. ■

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WPS

report

for Wisconsin Physicians

Volume VII, Number 6

November, 1978

Health Information Brochures

In addition to the health related films which WPS offers (discussed in the September, 1978 *Report*), WPS has five health information brochures available. These booklets deal with various aspects of achieving healthier and happier lifestyles. Each is available to interested individuals, organizations and community groups, and each can be tailored to appropriate patient education activities.

Drug Abuse: The Chemical Cop-Out is a 48 page booklet which provides basic, easily understood, candid information on dangerous drugs and narcotics. It also looks at drug abusers and examines some of the factors which may contribute to increased abuse.

The Alcoholic American is a 40 page booklet which describes varying degrees of alcohol dependency and the characteristics of progressive alcoholism. The problems of recovering from alcohol abuse and maintaining that recovery in a drinking world are discussed. The booklet can serve as a supplement to the film companion on alcoholism, *The Other Guy*.

Suicide: The Will To Die is a 32 page booklet which attempts to show that suicide is a serious community health problem. It illustrates that almost anyone may attempt suicide given a critical set of personal frustrations, failures and depressions. The booklet can serve as a supplement to the film of the same name.

How To Be A Wise Ol' Bird is a 13 page booklet designed to assist the senior citizen and retiree in setting up and maintaining a rewarding and healthy lifestyle after retirement. The brochure contains information on financial planning, health maintenance as well as general tips on enjoying one's newfound leisure time.

Consider Your Health is a 6 page brochure designed for use by the general public as a guide to preventive health care. The booklet provides information on how to create a self-health situation which minimizes use of inappropriate and expensive medical facilities and maximizes individual responsibility for preventive health maintenance.

Up to 25 copies of the brochures can be obtained free from WPS. There will be a nominal charge for orders of more than 25. Simply request the title and quantity of the brochure desired and mail the request to Communications Division, WPS, P.O. Box 8190, Madison, WI 53708.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

Complete Submission of Claims Data

Both you and WPS want to have your patient's claims processed as rapidly as possible. Claims which are held up for various reasons generate time-consuming correspondence between your office and WPS, while the patient becomes increasingly worried about the delay in payment. Clearly, anything that can be done at the start to facilitate claims processing is worth emphasizing. Therefore, here are a few suggestions which may seem very obvious but which, if consistently followed, will save needless correspondence in the long run.

First, whether or not you file on a standard WPS claim form, if you are sending a bill, WPS needs an itemized statement in order to process it. An itemized statement includes the date of service, description of service, charge for each service provided and, when appropriate, a diagnosis for the service or services. It is surprising how many claims are delayed in process because one or more of the above items is missing.

The diagnosis should be as complete as possible because, under some WPS contracts, payment may be approved for a service with one diagnosis but denied for the same service with another diagnosis. This is especially the case when medical treatment is administered in a hospital emergency room. Most WPS policies are specific about circumstances under which emergency room treatment is a payable benefit, and an incomplete diagnosis may precipitate an incorrect denial of benefits.

Second, along with the usual personal information, be sure to include the patient's subscriber or identification number. Policyholder records at WPS are accessible through the identification number and not the name. Therefore, a claim on which WPS cannot locate the policy number cannot be processed. Time is saved if you obtain the patient's subscriber number from the identification card at the time the service is provided and include it on your statement, double-checking to make sure the number is copied correctly.

Also important is making sure that the physician's 5 digit WPS provider number is included and correct on the claim statement, along with the name and address of the physician's office. WPS makes payments directly to the physician's office on the basis of the physician's provider number--the number assigned a physician or a physician's office by WPS. Payment may be delayed or may not be made at all if this provider number is incorrect or missing.

If you ever contact WPS regarding the status of a claim you have filed, be sure to have the above necessary information in your inquiry. If you telephone WPS, simply give the relevant claims information to the correspondent to whom you talk. If you write WPS, a convenient format would be to send an exact copy of the claim along with a short note with your questions. If for some reason WPS never received your original claim, the copy can be processed just as easily.

Following these guidelines will insure that claims filed with WPS are processed promptly, accurately, and efficiently--necessarily a concern of foremost priority for the patient, the physician's office, and WPS.

FAMILY PHYSICIAN: OPPORtunity for one or two in Northern Wisconsin resort town of Eagle River. New clinic facility next to hospital for four to six physicians to open June 1977. Drawing area includes entire Vilas County, parts of Oneida, Forest counties plus a large tourist population. If interested contact: Charles E Reevs, Admin, Eagle River Memorial Hospital, Eagle River, WI 54521. Tel: 715/479-4456. 4tfn/77

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis, a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

INTERNIST AND PEDIATRICIAN. Unique practice arrangement available with other medical specialists in Medical Arts Building, Sheboygan, Wis. Sheboygan offers excellent hospital facilities in addition to excellent family environment, located on the shores of Lake Michigan. For further information contact: William G Wagner, MD, 1225 North 8th St, Sheboygan, Wis 53081. 5tfn/78

WANTED: PSYCHIATRIST. INterested in part-time work (15-35 hours/week) at the Bureau of Social Security Disability Insurance, 310 Price Place, Madison, Wis 53705. If interested please write or call Henry A Anderson, MD, 310 Price Place, PO Box 7623, Madison, Wis 53707. Tel: 608/266-1989. 10-11/78

WANTED: FAMILY OR GENERAL practitioner to serve East Central Wisconsin small college town of 7,000, close proximity to community hospital with up-to-date facilities. Guaranteed base income with opportunity for partnership. Call or write for details to R S Pelton, MD, 315 Mt Zion Dr, Ripon, Wis 54971. Tel: 414/748-2875. 10tfn/78

INTERNIST WITH AN INTEREST in cardiology. Minneapolis-St Paul internists' group seeks associate who wishes to weight his practice with noninvasive cardiology. Electrocardiography, active coronary care responsibilities, and resident teaching responsibilities in contacts of group practice. Curriculum vitae and references mail to Dept 459 in care of the Journal. 7-12/78

FAMILY PHYSICIAN WANTED TO join group of four which includes three FPs and a general surgeon in lovely Cumberland, Wisconsin, situated on a clean beautiful lake. Clinic adjacent to 47-bed hospital. Salary and benefits negotiable; partnership in one year. Contact: D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 9tfn

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COMMUNITY PSYCHIATRY: IMmediate opening for an experienced psychiatrist interested in full-time employment within a comprehensive community mental health system. We serve a county of approximately 140,000 in southcentral Wisconsin, operate two mental health clinics and a 450-bed Health Care Center, and are organized into specialized programmatic units for: admission-stabilization; alcohol and drug detoxification and treatment; residential care for the retarded; half-way house; behavioral unit for chronically mentally ill; psychogeriatric unit; day hospital program; community aftercare; total care nursing home facility; outpatient services; and a community education unit. Assignment is flexible according to the skills and interests of the psychiatrist, and offers an unusual opportunity to participate in a truly comprehensive community program. Board eligibility and Wisconsin licensure are required. Salary range from $45,000-$48,000 annual, with full fringe package including retirement, fully paid malpractice insurance, and four weeks of vacation. Contact: M J Chapman, MD, Medical Director, or Wm T Boerum, Administrator, Rock County Health Care System, PO Box 351, Janesville, WI 53545. 608/755-2504. 11/78*

PEDIATRICS, FAMILY PRACTICE, internal medicine, urology and ENT positions available with a 13-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 9-12/78

BOARD CERTIFIED, OR BOARD cligible, pediatrician wanted in Wisconsin multispecialty group of 26. College town of 35,000 between Madison, Milwaukee, and Chicago. New clinic building adjacent to new hospital. Very competitive income. Write: W S Freeman, MD, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, Wis 53511. 7-12/78

WISCONSIN-GREEN BAY. FULL time position open for a hospital based Emergency Room physician. Attractive opportunity in emergency department with 21,000 plus yearly visits. Pleasant medium size city with excellent recreational areas nearby. Salary $58,000 plus paid malpractice and complete benefit program (paid vacation, educational leave, life insurance and pension plan). Submit CV to: Administrator, St Mary's Hospital Medical Center, 1726 Shawano Ave, Green Bay, Wis 54303. 10-11/78

FAMILY PRACTITIONER, PHYSiatrist and ENT physician needed by 31-man multi-specialty clinic next to 350-bed hospital. Fifty thousand population city in beautiful Mississippi River Valley with sophisticated medicine and excellent cultural attractions. William J O'Leary, MD. 815 South 10th St, LaCrosse, Wis 54601. Tel: 608/782-9760. 7tfn/77

CARDIOLOGIST, 30, ABIM ELIGIble, eligible cardiology boards June '79. Cath training in prestigious university in California, well trained in noninvasive techniques, pacemakers, Swanganz, seeks group/partnership, hospital based practice. Available July 1979. Will do some internal medicine. Write Dept 463 in care of the Journal. p11/79

WANTED: FAMILY PRACTICE physician to join a group of nine family practitioners, one general internist and one general surgeon in a rural community in northwestern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wisconsin. Tel: 715/234-9031. 11-12/78

PUBLIC HEALTH COMMISSIONer: City of Racine is seeking a physician with experience in administrative or Public Health medicine to direct the activities of a 40 member City Health Department. This challenging position involves a full range of Public Health activities, including budget and management responsibility, special projects, planning, policy, and staff development. Salary range $36,100-$43,900 commensurate with qualifications and experience. Ideal southeastern Wisconsin location offering excellent recreational activities on beautiful Lake Michigan and only 30 minutes from Medical College of Wisconsin and one hour from the Chicago area. Interested candidates are invited to address their curriculum vitae to James C Kozina, Personnel Director, 730 Washington Ave, Racine, Wis 53403. Affirmative Action Employer. p11-12/78

AVIATION AND NUCLEAR MEDIcine—Other specialties also needed, $33,500 or higher starting salary based on qualifications and experience, plus noncontributory retirement plan, malpractice insurance paid, and full healthcare benefits. East and West coast locations. Please write to L G Tenneson, NRD, 611 N Broadway, Milwaukee, Wis 53202. 1-12/78

CLINICAL PSYCHOLOGIST. ROCK County Health Care Services, a comprehensive community mental health system, has a vacancy for an outpatient clinic supervisor. The position supervises eight to ten professional and para-professional personnel in the delivery of mental health, alcohol, and drug abuse treatment. Experience in a team approach to mental health treatment; graduation from an accredited four-year college or university, supplemented by a doctoral degree in clinical psychology is required. The successful candidate will possess a thorough knowledge of psychological and psychometric techniques and their application to a wide variety of mental disorders. He, she will have the ability to provide direction for a comprehensive outpatient mental health program for children and adults. A successful candidate must be able to be licensed by the State of Wisconsin as a clinical psychologist. Send a complete resumé and salary history to Rock County Health Care Center, PO Box 351, Janesville, WI 53545. Attention: Personnel Office. 11/78*

MEDICAL FACILITIES

FOR SALE: PHYSICIANS SUITE and practice, full-equipped in medical building. Ideal for general practice or internal medicine. 5148 N Teutonia Ave, Milwaukee. Three blocks from St Michael's Hospital. Call Art Smith 414/462-7570 or 414/464-7240, or evenings contact Mrs Duffy 414/352-4469. g5tfn/78

MEDICAL CLINIC SPACE AVAILable. Janesville Road and Pioneer Drive, Muskego. 2,500 sq ft on ground floor. Modern, move-in condition. Please contact: Roger Bothe, John Herschede & Associates, Inc. Tel: 414/933-0585. 7tfn/78

FOND DU LAC FACILITY. COMplete medical practice suite available soon. Suitable for group practice of five or six, or a pair and three. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd, Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOR RENT: OFFICE SPACE available. A new modern medical building. Located southwest side of Milwaukee. X-ray and laboratory facilities available. Close proximity to two hospitals. Call 414/643-4470. 11tfn/78

FOR SALE: HAMILTON WOOD exam table, small sterilizer, 4-tube centrifuge. Call: 414/271-7194. 11/78

NEW PROFESSIONAL OFFICE. 1300 sq ft modules for lease in Beaver Dam, Wis. Tel: 414/887-1677. 10-12/78

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1978 WISCONSIN

Dec 13: In-Depth Teaching Program, Madison General Hospital.

1978 OTHERS

Dec 4-8: *Fluid and Electrolyte Balance, Hypertension and Renal Diseases,* American College of Physicians Postgraduate Course, Northwestern University Medical School and Northwestern Memorial Hospital, Chicago, Ill. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

1978 AMA

Dec 2-6: House of Delegates Interim Meeting. Chicago.

Dec 7-10: Winter Scientific Meeting. Las Vegas.

1979 WISCONSIN

Jan 4-10: Medical College of Wisconsin annual postgraduate course in *Gynecological Pathology, Cytogenetics and Endocrinology,* at Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Jan 17-19: 9th Annual Winter Refresher Course for Family Physicians at The Pfister Hotel and Tower, Milwaukee. Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233. Tel: 414/933-0700.

Jan 18: In-Depth Teaching Program, St Mary's Hospital Medical Center, Madison.

Jan 19: *Diagnostic Ultrasound for the Clinician,* sponsored by the Radiology Department, Madison General Hospital, Madison, WI. A morning symposium approved for 4 hours of Category I CME credit for PRA-AMA. AAFP credit applied for. Faculty: Richard Friday, MD; Robert Corliss, MD; Michael Curtin, MD; William Zweibel, MD; David Atwell, MD; Robert Starshak, MD; James Zegzebski, PhD. Info: Howard Christensen, CME Coordinator, 202 S Park St, Madison 53715. Tel: 608/267-6062

Feb 6-8: 16th Annual Telemark Symposium and Ski Outing, sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians, at Mount Telemark, Cable. Six hours of CME credit, and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove, WI 53122.

Feb 13-14: Wisconsin Chapter, American College of Emergency Physicians, Alpine Valley Resort, East Troy. Subject: Cold injuries—recreational and industrial.

Feb 21: In-Depth Teaching Program, Methodist Hospital, Madison.

Mar 15: In-Depth Teaching Program, UW Center for Health Sciences, Madison.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835.

May 3-5: Wisconsin Chapter: American Academy of Pediatrics, Pioneer Inn, Oshkosh, Wis 54901.

May 18-23: American Holistic Medical Association Annual Meeting, at University of Wisconsin, LaCrosse. Cosponsored by The American Society of

Contemporary Medicine and Surgery. Forty hours of Category I CME credit. Info: AHMA, Route 2, Welsh Coulee, LaCrosse 54601.

June 22-24: 31st Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians. The Abbey Resort, Fontana, Wis. 15 hours of CME and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove 53122.

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

Alaska Cruise

July 28 - Aug. 11, 1979

Common Dermatological Problems

Sponsored by Dermatology Departments of University of California at San Francisco and Northwestern University

Depart San Francisco on "SS Fairsea" of Sitmar Cruises and sail to Vancouver, Ketchikan, Glacier Bay, Victoria and many other stop overs along the way to Alaska. Aboard ship, attend classes designed to review diagnosis and management of acne, warts, tumors of the skin, therapy, infections of the skin, viral infections, and cutaneous signs of internal disease. The course is designed to meet the needs of both the dermatologist and the generalist, family physician or pediatrician. Small group seminars will be given.

Faculty: **John M. Knox, MD,** Baylor College of Medicine; **Howard I Maibach, MD,** University of California at San Francisco; **Rees B Rees, MD,** University of California at San Francisco; **Henry H Roenigk, Jr, MD,** Northwestern University.

Info: Henry H Roenigk, Jr, MD, Dept of Dermatology, Northwestern University Medical School, 303 East Chicago Ave, Chicago, Ill 60611. 11/78

1979 NEIGHBORING

Mar 5-8: *Neurology for the Internist,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Mar 7-9: Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists, Conrad Hilton Hotel, Chicago.

May 16-18: *Cardiac Auscultation and Cardiac Examination,* American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St, Philadelphia, Pa 19104.

1979 OTHERS

Jan 25-27: *National Conference on Forensic Medicine and Society,* sponsored by American Society of Law & Medicine and the Pittsburgh Institute of Legal Medicine, at the Hotel del Coronado, outside San Diego, Calif. Info: ASLM, *Forensic Medicine and Society,* 454 Brookline Ave, Boston, MA 02215.

Mar 4-6: Winter Pediatric Conference, sponsored by Marshfield Clinic Department of Pediatrics, at Powderhorn Ski Lodge, Bessemer, Mich. Info: H James Nickerson, MD, Chairman, Dept of Pediatrics, Marshfield Clinic, Marshfield, Wis 54449.

Apr 4-6: National Conference on High Blood Pressure Control, The Washington Hilton, Washington, DC. Sponsored by the National High Blood Pressure Education Program Coordinating Committee. Info: Conference Headquarters, NCHBPC, 1501 Wilson Blvd, Suite 600, Arlington, Va 22209; tel 703/527-4500. g9/78-2/79

Apr 4-6: American Cancer Society, National Conference - Urologic Cancer, 1979. Los Angeles Hilton Hotel, Los Angeles, CA. Info: Urologic Cancer Conference, American Cancer Society, 777 Third Ave, New York, NY 10017.

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

18th National Conference on the Detection and Treatment of Breast Cancer

Mar 5-8, 1979 • Atlanta, Ga

Conference devoted to progress in detection and treatment of breast cancer. To feature internationally recognized authorities in the fields of radiology, surgery, pathology, obstetrics and gynecology, epidemiology, and other medical and nonmedical specialties.

Emphasis placed on team approach to cancer management and involvement of various specialties in major problem areas including: high-risk benign disease, minimal breast cancer, radiation risks, detection programs, invasive cancers, the relationship of gynecological disease and breast disease, and rehabilitation.

Sponsored by American College of Radiology. Co-sponsored by College of American Pathologists, Educational Foundation of the Society of Plastic and Reconstructive Surgery, American Academy of Family Physicians, in cooperation with American College of Obstetricians and Gynecologists.

Approved for Category I credit under the AMA continuing medical education criteria.

Further info: American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, MD 20015. Tel: 301/654-6900.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

University Club, 924 E Wells St, Milwaukee

1978 Meeting Dates

Nov 28: Abduction Deficiencies, *William Scott, MD,* Associate Professor of Ophthalmology, University of Iowa, Iowa City, Ia

1979 Meeting Dates

Jan 23: Retinal Diseases—Fluorescein Angiography—Aids in Diagnosis and Treatment, *Trexler Topping, MD,* Dept of Ophthalmology, Medical College of Wisconsin, Milwaukee, Wis

Feb 24: *Jerry Shields, MD,* Assistant Professor, Wills Eye Hospital, 1601 Spring Garden St, Philadelphia, Penn

Mar 27: *Peter Laibson, MD,* Professor of Ophthalmology, Head, Corneal Unit, Wills Eye Hospital, 1601 Spring Garden St, Philadelphia, Penn

Apr 24: The Management of Aphakia with Contact Lenses, *Perry Rosenthal, MD,* 33 Pond Ave, Brookline, Mass.

May 11: Drug induced Ocular Side Effects, *Frederick Fraunfelder, MD,* Professor and Chairman, Dept of Ophthalmology, University of Arkansas, Little Rock, Ark

Info: Contact John L Sella, MD, 6114 West Capitol Dr, Milwaukee, Wis 53216

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Jan 27-31: American College of Allergists, San Francisco. Info: F P White, 2141 14th St, Boulder, CO 80302.

Mar 22-29: American Society of Clinical Pathologists and College of American Pathologists, New Orleans. Info: J L Normoyle, 2100 W Harrison St, Chicago, Ill 60612.

Apr 2-5: American College of Surgeons, (Spring Meeting), Denver. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Apr 26-29: Annual Meeting, American Society of Internal Medicine, New Orleans, La.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

NETWORK FOR CONTINUING MEDICAL EDUCATION

15 Columbus Circle, New York City 10023

Schedule of Upcoming Programs

Nov 27-Dec 10

Cardiac Auscultation, with John F Stapleton, MD, Medical Director, Professor of Medicine and Antonio C deLeon, Jr, MD, Professor of Medicine, Director, Cardiac Diagnostic Laboratories, Assistant Dean for Continuing Medical Education, both are members of the Department of Cardiology at Georgetown University School of Medicine, Washington, DC, also Rafael C Sanchez, MD, Director, Family Practice Residency, Washington-St Tammany Charity Hospital, Bogalusa, Louisiana.

This four part telecourse is cosponsored by Georgetown University School of Medicine, Washington, DC, and is acceptable for Category 1 credit by the American Medical Association and by the American Academy of Family Physicians for Prescribed credit.

Dec 11-Dec 24

Chest Radiographs: Normal and its Variations and *Pleural Fluid,* with Anthony V Proto, MD, Associate Professor, Department of Radiology, at the University of Cincinnati College of Medicine, Cincinnati, Ohio.

Penetrating Wounds of the Abdomen: When to Operate, with John Hansbrough, MD, Surgical Director and Ben Eiseman, MD, Professor Surgery, both at the University of Colorado Medical Center Emergency Department, Denver.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

9th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

Jan 17-19, 1979

The Pfister Hotel and Tower, Milwaukee

Sponsored by the Department of Family Practice, The Medical College of Wisconsin and Southeastern Chapter of the Wisconsin Academy of Family Physicians

Course Director: *Thomas F Garland, MD,* Associate Professor of Family Practice, Program Director, Family Practice Residency Program, Deaconess Hospital

Approved 21 credit hours of CME Category 1 credit by the AMA-PRA

Info: Mrs Susanna Rechlitz, Conference-Manager, Department of Family Practice, 610 North 19th St, Milwaukee, Wis 53233. Tel: 414/933-0700

DIAGNOSTIC ULTRASOUND FOR THE CLINICIAN

Friday, Jan 19, 1979

Bolz Auditorium/Madison General Hospital, Madison

7:45 am	Registration
8:00 am	Physics of Ultrasound, *James Zegzebski, PhD*
8:30 am	Pediatric Ultrasound, *Robert Starshak, MD*
9:00 am	The Gall Bladder, Pancreas and Liver, *David Atwell, MD*
9:30 am	The Kidney and Retroperitoneal Space, *Michael Curtin, MD*
10:00 am	Coffee and rolls
10:15 am	Carotid Imaging and Doppler Ultrasound, *William Zweibel, MD*
10:45 am	Obstetrics, *Richard Friday, MD*
11:15 am	Gyn, *Michael Curtin, MD*
11:35 am	Echocardiography, *Robert Corliss, MD*
12:05 pm	Real Time Ultrasound, *Richard Friday, MD*
12:20 pm	Adjournment

Info: Howard Christensen, CME Coordinator, 202 S Park St, Madson 53715. Tel: 608/267-6062.

CONTRIBUTIONS—CES FOUNDATION
September 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1978.

Unrestricted

Ralph F Hudson, MD—*Voluntary Contribution*

Restricted

Membership Dues—*Aesculapian Society*
E Wayne Brown Sale of Stock—*Brown Unitrust*

Memorials

Dr-Mrs TW Tormey Jr—*James E Miller, MD (Tormey Memorial Medallion Fund)*
Dr-Mrs Robert T Schmidt; Mrs Robert W Burns—*Ralph Curtis Smith (Brown County Loan Fund)*
Dee Miller—*Myrle Sturlaugson (Student Loans)*
Bill and Mary Angell—*Donald E Wing; Myrle Sturlaugson (Barbara Scott Maroney Memorial Fund)*
Mr-Mrs ER Thayer; Family and Friends of JW Boren, Jr—*J W Boren Jr, MD*
Dr-Mrs EJ Nordby; AP Schoenenberger, MD—*James E Miller, MD*
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STATE MEDICAL SOCIETY OF WISCONSIN

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Madison, Wisconsin 53701

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News You Can Use

ICD-9-CM OR CPT-4?

On September 14, HEW's Health Care Financing Administration and Public Health Service announced their endorsement of the International Classification of Diseases 9th Revision, Clinical Modification (ICD-9 CM). They stated that this system "will be used to coordinate statistics on health problems and health care in hospitals and similar institutional environments." The primary concern is whether ICD-9-CM is now mandated for use in reporting medical services and procedures for governmentally funded health-care programs. The AMA has voiced vigorous objections to HEW expressing its opposition to ICD-9-CM being mandated in general. It has strenuously objected to any potential use of the ICD-9-CM procedural volume for reporting physician procedures and services since the CPT program, in development for more than a decade, has been developed precisely for this purpose. According to the AMA, many state medical associations have endorsed the CPT system and have urged third party carriers to adopt it. (CPT-4 is the procedure coding system endorsed on the recently developed Wisconsin Uniform Claim Form.) The AMA strongly urges physicians to continue using CPT-4 for reporting procedures and services to all third party intermediaries. Adhering to the 1978 House of Delegates' action, SMS also urges the continued use of CPT-4 for procedure coding. The Claim Form and Code Committee appointed by Physicians Alliance Commission, will be following this issue and will keep the membership apprised of developments.

IN-DEPTH TEACHING PROGRAMS SLATED

The Charitable, Educational and Scientific Foundation of the State Medical Society, in conjunction with the Wisconsin Academy of Family Physicians, is again sponsoring In-Depth Teaching Programs for physicians at four Madison hospitals this winter. The programs are scheduled for: December 13, 1978 at Madison General Hospital; January 18, 1979 at St Mary's Hospital Medical Center; February 21, 1979 at Methodist Hospital, and March 15, 1979 at the UW Center for Health Sciences. Each program qualifies for four hours of Category I credit for the Physicians Recognition Award of the American Medical Association. Registration is $50 for the series or $15 per program for members of SMS WAFP or the Wisconsin Association of Osteopathic Physicians and Surgeons. For nonmembers of these groups, registration is $80 for the series or $25 per program. For further information contact Arlene Meyer at the SMS Health Services (formerly Quality Care) Division, 257-6781 or toll-free at 1-800-362-9080.

PRACTICE MANAGEMENT PROGRAMS PLANNED FOR RESIDENT PHYSICIANS

Senior year residents can get some help on starting a medical practice in special seminars sponsored by the State Medical Society of Wisconsin, the Wisconsin Institute of Certified Public Accountants, and the State Bar of Wisconsin. The one-day seminars are scheduled for Saturday, January 13, 1979 in Madison and Saturday, January 20, 1979 in Milwaukee. They are designed to give senior residents a basic understanding of the financial and legal considerations involved in establishing or joining a medical practice. Matters such as purchase or rental of equipment, professional liability, cash control and estate planning will be covered. Registration fee is $30 and will cover course materials and luncheon. For more information contact Peter Wood at SMS offices in Madison. ■

Front Page Update

STATISTICAL REPORT OUT ON STATE PHYSICIANS

The Bureau of Health Statistics recently released its 1978 report detailing demographic and descriptive statistics concerning all physicians (MD and DO) licensed to practice in Wisconsin. Some of the highlights in this report include:

- As of February 15, 1978 there were 6,423 physicians in active practice in Wisconsin. One hundred additional physicians from outside Wisconsin practice part time in the state.
- Over half of Wisconsin physicians are in primary care specialties.
- Half of Wisconsin physicians are located in Milwaukee and Dane counties.
- Wisconsin physicians reported an average of 49 hours a week in patient care.
- Forty percent of physicians reported some kind of salaried employment. Thirty percent of these are also in private practice.
- There has been a net increase of 158 physicians since 1977.
- Thirty percent of physicians are between 30 and 39 years old. Less than eight percent are 65 or older.

INFLUENZA VACCINE FOR HIGH-RISK CHILDREN

The Committee on Infectious Diseases of the American Academy of Pediatrics reports that some areas of the country have inadequate supplies of the "subvirion" influenza vaccine recommended for high-risk children under the age of 13. In view of this, the Committee has recommended that, where the subvirion youth formulation is not available, the subvirion adult formulation is used in high-risk children under the age of 13 using the same volume and dosage timing as recommended for the subvirion youth formulation. The dosage schedule for high-risk children 3-12 years of age is 0.25 cc given intramuscularly or subcutaneously on each of 2 occasions 1 month apart; for high-risk children 6-35 months old, it is 0.15 cc on each of 2 occasions 1 month apart.

SCHEDULE WPPN SLIDE SHOW FOR YOUR NEXT MEETING

The SMS Health Planning Commission and staff have prepared an excellent audiovisual program explaining the nature and scope of the Wisconsin Physicians Planning Network (WPPN). WPPN is designed to promote physician participation and influence in all stages of the health planning process. Be sure to schedule the WPPN audiovisual program for your next county medical society meeting or other physician meeting.

NELSON RESIGNS FROM UW HEALTH POST

Bernard W Nelson, MD announced last month that he is resigning as acting vice chancellor for health sciences at the UW Medical School. Nelson will leave April 1 to become vice president of the Kaiser Family Foundation in Palo Alto, Calif. Nelson was the focus of controversy last summer when he forced John Renner, MD to resign as chairman of the school's family practice program. At that time the State Medical Society and other groups petitioned that Renner be allowed to stay on. Nelson said he is reluctant to leave the UW just as the new Clinical Science Center is opening but added that becoming vice president of the Kaiser Family Foundation will better enable him to "bring innovation and change to the health care delivery system in the United States." ■

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN MEDICAL JOURNAL
1903 - 1978 75th ANNIVERSARY YEAR

USPS 688-360
Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

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NATIONAL ADVERTISING REPRESENTATIVE: State Medical Journal Advertising Bureau, Inc, 711 South Blvd, Oak Park, Ill 60302. Ph 312/383-8800.

LOCAL (WISCONSIN) ADVERTISING: Contact: Mrs Mary Angell, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701. Ph: 608/257-6781.

SUBSCRIPTION RATES: Members, $6.00 per year (included in dues): non-members, $12.00. Single copy, $1.50, previous years, $3.00 single copy; Blue Book, $5.00.

SECOND CLASS POSTAGE PAID at Madison, Wisconsin, and at additional mailing offices. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 330 East Lakeside Street. Mailing address: Box 1109, Madison 53701.

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State Medical Society of Wisconsin

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Wisconsin Physicians Planning Network—Another chance

THE NEWLY ORGANIZED Commission on Health Planning held its first meeting on September 21. On its agenda was the discussion and approval of the Wisconsin Physicians Planning Network. The WPPN will establish a physician task force in each HSA area through which physicians can monitor and influence the work of their respective HSAs. Liaison will be maintained with the State Health Policy Council and other state health planning agencies. The WPPN will be organized with the assistance of county medical societies and hospital medical staffs.

For many years nominating groups have encountered mass physician apathy as they have sought suitable candidates for positions on various public service committees and task forces, and for the same number of years physicians have loudly complained about lack of medical input at hearings conducted by those committees on which they have been too busy to serve. Many of the problems medicine faces today have been compounded by our own unwillingness to contribute our time and knowledge when policy is being shaped.

The Wisconsin Physicians Planning Network offers yet another opportunity for the medical profession to participate in the settlement of its own destiny. If you are called to serve, please consider it carefully; and if you have the necessary qualifications, say *yes* for a change!—WJB

The future of the *Wisconsin Medical Journal*

RECENTLY THE Finance Committee of the State Medical Society Council contemplated its annual budget. Once again it was proposed that one possible saving could be accomplished in the area of the *Wisconsin Medical Journal.*

Whether this is considered an opinion or an editorial, and I am sure that the Editorial Board concurs in this, the Society would be ill-advised and short-sighted to curtail or terminate the publication of its traditional journal. When this has been suggested in the past, it was concluded that the Society would soon by necessity be publishing a series of "bulletins" that would really proliferate in volume and cost.

The Society obviously needs some type of official publication. The present *Journal* is efficiently produced by a paid staff of two. For several years the actual printing of the *Journal* has been out of state at a saving of thousands of dollars compared with local costs. An optimistic note is that this year for the first time in fifteen years (when the Kefauver investigation changed the pattern of pharmaceutical advertising) the number of pages of national advertising has increased by over 50%. Some of this can be attributed to a more aggressive sales representative for the State Medical Journal Advertising Bureau (the *Wisconsin Medical Journal* is one of 34 members), but some of this is on a selective basis and not all other journals have fared as well.

The *Wisconsin Medical Journal* is actually many things. Probably the two major functions are medical education through scientific articles and the dissemination of official Society proceedings. In addition it is a means of expressing opinions and presenting news of its members.

The Editorial Board certainly is not self-serving in advising that the *Journal* be continued. Indeed, the board members are generally long-term appointees who are not reimbursed for travel, postage, secretarial help, or other out-of-pocket expenses.

If South Dakota, Delaware, and Rhode Island, with physician populations just a fraction of that of Wisconsin, can publish state medical journals, certainly Wisconsin should be able to continue its own *Journal.* Having this month rounded out 75 years of publication, it is sincerely urged that the *Journal* be continued.—VSF

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Too young to die?

THE FINANCE COMMITTEE of the Council met October 27 to work over the 1979 budget. Even though there will be a dues increase, cuts in services must still be made if a balanced budget is to be achieved.

Every year a red ink item which stands out sharply is the *Wisconsin Medical Journal*. For 1978, expenses over income are projected at $45,315.00; and for 1979, $47,255.00—in other words, the *Journal's* cost will amount to roughly $10.00 per member.

Our hard-nosed Finance Committee chairman looks upon this as an untenable situation and has raised the question of abandoning the *Journal* in favor of a less costly communication vehicle. The fact that the *Journal* has been published since 1903 touches him not at all. Tradition and nostalgia, not to mention past services to the physicians of the state, fail to move him as he cuts to the bare bones.

One wonders, though, whether the value of the *Wisconsin Medical Journal* can be expressed in dollars and cents. It is true that the lag time between submission of material such as news items and actual dissemination is much too long—but what can you expect of a monthly publication? That sort of material is better suited to a newsletter format such as is employed in MEDIGRAM.

Scientific articles of improving quality are being submitted in increasing numbers by Wisconsin physicians. In publishing these papers the *Journal* provides a forum which would be otherwise unavailable to many writers. It also affords a means of ethical, legitimate advertising of new services to colleagues.

Then, too, some of the regular features would be missed if the *Journal* were to be discontinued. A valued means of keeping track of old friends has been the PHYSICIAN BRIEFS Column—of particular appeal to the older members. And the same can be said for the OBITUARIES. Even the MEDICAL YELLOW PAGES are an interesting section which offers a worthwhile service.

Setting priorities for the best possible use of dues dollars is always difficult. While everyone agrees that in tough times it is necessary to cut out the fat and the frills, there are some intangible factors which deserve consideration. At 75, the *Journal* may still be too young to die. —WJB ■

The WMJ in perspective

THERE MAY HAVE BEEN a misunderstanding of the circumstances related to the suggested termination of this journal. It seems this subject has been periodically discussed over the years by both the council and its Finance Committee. However, at the last meeting of the Finance Committee, by *formal action*, this body did *approve* the 1979 budget for the WISCONSIN MEDICAL JOURNAL. Reportedly, following this formal action, there was a discussion relative to cost and a more timely delivery of the journal to the membership. This would seem to be a prudent prerogative of this committee or the Secretary or the Editorial Board. There was, however, *no formal recommendation* by the Finance Committee to consider termination of this organ. Had there been

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such a formal recommendation, I would have been as upset and concerned as my colleagues on the editorial staff whose comments appear here. However, from reports obtained from personal contacts, the comments relative to termination of the journal were made informally in response to a provocative and perhaps belligerent question. In my opinion, the evoked response by my two colleagues may be out of proportion to the stimulus.

History does have a way of repeating itself and should this issue, again, be considered, I suggest the Council, the Finance Committee and the entire membership of the Society consider the following:

(1) The purpose of the Medical Society: If termination were to be considered, it would likely necessitate rewriting the Constitution of the Society, as the express purpose of the Society is to "extend medical knowledge and advance medical science." Certainly the WISCONSIN MEDICAL JOURNAL is the major vehicle through which this is accomplished. The only other major effort in this area would be the Annual Meeting.

(2) A second purpose of the Society expressed by the Constitution is to "promote open communication and understanding among physicians." Certainly the WISCONSIN MEDICAL JOURNAL contributes a great deal to this area.

If termination were to be considered, it would be very important that the effect of such an action on the tax-exempt status of the Medical Society be very carefully examined. Presently, it is my understanding that the Medical Society holds a 501(c)(6) tax exemption which might be very seriously jeopardized by termination of this publication. Such an action would most likely cause the IRS to reconsider our exempt status. The JAMA just recently had some difficulty with the Internal Revenue Service relative to the amount of advertising in the journal. Medical societies are presently being scrutinized by the IRS concerning their nonprofit status. Loss of the nonprofit status would not only require the Society to pay federal income taxes but also might greatly increase the cost of postage for the Society.

Presently the journal costs each member of the Society $10.80 which is taken from dues. This seems to be a very modest subscription cost. Most major subspecialty society members are assessed $25.00 per year for support of that particular society's journal. I might add that if one is to be a member of such a society, subscription to the journal is mandatory.

At present the type of accounting system used by the State Medical Society does not put the WISCONSIN MEDICAL JOURNAL in a very favorable light. When being considered along with all other departments, it is important to remember that the WISCONSIN MEDICAL JOURNAL generates more non-dues revenue than any other single department. It is estimated in 1979 that revenues from the WISCONSIN MEDICAL JOURNAL will approximate $75,000 which is 64 percent of the total operating cost.

Certainly, a large number of the pages in the journal are devoted to "promoting open communication and understanding among physicians." The accounting system does not allow credit to the WISCONSIN MEDICAL JOURNAL for the cost of these pages. When one considers news items, medical announcements, etc, a considerable portion of this organ is devoted to such announcements.

Aspects of this problem concerning the emotional and traditional issues have been adequately covered by my colleagues.

In short, I would think it would be very difficult for the State Medical Society to fulfill its missions relative to medical knowledge, the advancement of medical science, and promote open communications without a publication such as the WISCONSIN MEDICAL JOURNAL. I would not argue against consideration of a change in format or that more timely delivery would be helpful. I would also suggest that perhaps it contain more scientific information. I would hope that these points would be very carefully considered by the Council and the Finance Committee in the next discussion relative to the termination of this publication.

The final decision, however, as to termination or a major change in format rests with the membership whose dues support this activity. Certainly, an expression from the membership regarding these issues would be welcomed.—RDS ■

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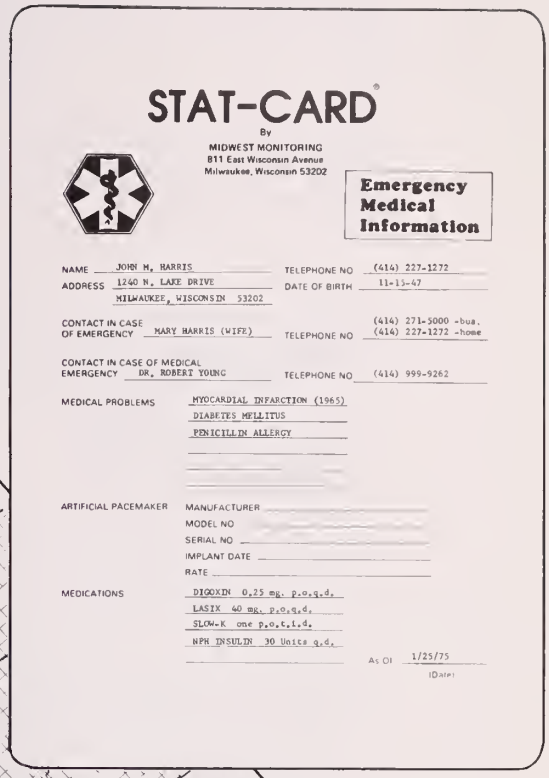

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Opinion/Dialogue

HSAs: They're here, like them or not!

ALTHOUGH THE MEMBERS of the Editorial Board felt the editorial by Doctor Boulanger entitled, "The meaning of HSA," (October issue) was suitable for publication, it does not express my position on this subject and perhaps does not reflect the feelings of many physicians in the State.

While I wholeheartedly agree with Doctor Boulanger that it is unfortunate these issues are debated in the press and that the premature release of information is deplorable, I wonder if these can be directly attributed to the HSA.

I, again, take issue with this type of editorial in that it does not face the facts of life. The Health Systems Agency is, indeed, in place, does have teeth, and will affect our professional lives in spite of almost anything that we can do. My personal belief is that it is not to the advantage of the medical community to continue to debate whether these are worthy organizations but rather to try and find a way in which we can work together.

I suspect I may be in the minority, but I would certainly welcome an expression of the membership of the State Medical Society as to their position relative to the Health Systems Agency.

RICHARD D SAUTTER, MD
Marshfield

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SINCE THE FOLLOWING comments were rejected earlier this year for publication as an editorial, I now offer them as an opinion:

In May 1977 there appeared an editorial about the $300,000 paid to insurance agents by physicians (and hospitals and nurse anesthetists) who obtained their liability insurance through the State Liability Plan.

The January 1978 Medical GREEN SHEET included a note on how to circumvent this if the agent did not assist you in the preparation of your renewal. This stated that "if you obtain your liability insurance through the State Liability Plan (as 3,000 physicians do), and if you fill out the application or the renewal form *yourself*, be sure to write 'no commissions should be paid to the insurance agent of record' on the bottom of the application." Although the physician will not immediately or directly benefit by this, it does increase the reserves in the state plan (see article in November issue of WMJ).

If the applying physician does not so indicate, a commission of $125, new and renewal, will be paid to an insurance agent automatically. For physician applications as much as $400,000 may have been paid out in commissions during the 38-month period ending June 30, 1978.

As was emphasized in the original editorial in 1977, almost any physician should be able to fill out his/her own application form which is required annually.

VICTOR S FALK, MD
Edgerton

The new copyright law

THE NEW COPYRIGHT LAW is very disturbing in that it inhibits the promulgation of scientific information. The law and regulations are ambiguous and yet to be tested. It appears, at least to me, that the intent is to increase the publishers' revenues. This is very distasteful. A publisher can be viewed only as a glorified reproduction unit. Their copy is furnished to them at no cost. They are not even asked to make a judgment as to the quality of the material, which is done by the editorial boards of the journals. Still, the publishers retain the copyright. If the material is to be copyrighted, it should fall to the authors.

The primary purpose of medical societies and specialty groups is for the express purpose of exchanging scientific information. Any restriction on this purpose defeats this concept. Medicine is a rather unique business in that there are no "trade secrets." In fact, every attempt is made to share advancements in medicine with all who practice, in order that the quality of patient care can be upgraded globally.

There should be no restriction for anyone who wishes to make 100, or even 1,000 copies of whatever material is published in scientific journals, for the end result is to provide better patient care. If even one patient does not receive appropriate care because of the restrictions of photocopying any material in the scientific literature, then the whole concept of why physicians publish papers is destroyed.

At the last meeting of the Editorial Board of the *Wisconsin Medical Journal,* it was proposed that the Journal's current policy of reproducing its copyrighted material continue whereby the Journal and author jointly grant permission to reprint in quantity when it is for the noncommercial purpose of scientific or educational advancement. The Board also agreed that photocopying for the same purpose be allowed in order that its material can be freely disseminated. This is exemplary. I have written many of the specialty societies of which I am a member, with disappointing results.

I can find no reason for the change in the copyright law with the exception of the fact that it increases publishers' revenue. I, for one, would be happy to pay higher subscription fees and stop the erosion of our ability to promulgate scientific information.

I would encourage all of you who feel similarly to write the societies of which you are a member, encouraging them to issue a disclaimer relative to photocopying of scientific information.

RICHARD D SAUTTER, MD
Marshfield

"Blueprint for socialism"—redrafted

MARVIN G PARKER, MD, chairman of the State Medical Society's Commission on Health Planning, in the October WMJ states that labeling the 1978 Wisconsin State Health Plan as a blueprint for socialism is unfair.

The editorial comment in the June WMJ did indeed indicate that the health plan was designed to steer medicine in the direction of socialism.

In the October WMJ Doctor Parker recommends that the physicians of the State of Wisconsin cooperate with the State Health Plan so that they can "have an impact on the policies and objectives of the State Health Plan. Our goal is to outplan the planners, and I think we can do it."

Philosophically some of us are not all enthralled by the planning process. When the Health Services Administration conducted hearings, it interviewed radiologists and pathologists in northeastern Wisconsin. After four days of hearings in which the planners asked innumerable questions of the physicians, they adjourned the meetings only to return within two weeks with a comprehensive set of "guidelines" for the practice of pathology and radiology. If the "cooperating" physicians had not given the planners knowledge of their specialties, they would have been totally unable to establish their set of guidelines. Some physicians feel that in dealing with the Health Services Administration one should adopt the same attitude that one has in a threaten malpractice situation. Tell 'em nothing!

If physician cooperation with the Wisconsin State Health Plan were 100 percent and the entire plan came to fruition over the next five years, what would be the next series of restrictive and stultifying covenants with which we would have to cooperate in 1983?

Lee Dreyfus, the Governor-elect of Wisconsin, during his campaign stated, "Government is simply intruding in thousands and thousands of places government does not belong—and then overtaxing its citizens in the bargain." Many physicians agree with this concept. Yet, when you talk to physicians, they all speak of the inevitability of a government takeover of medicine. Cooperation with the Wisconsin State Health Plan will only smooth the way to this takeover.

The idea of planning appeals to many because it sounds like a logical extension of reason to problem-solving. The actual record of planning, however, is not good. We have had extensive planning in agriculture, oil and gas regulation, nuclear energy, steel import quotas, wages and prices, military service, subsidized housing, veteran health care, and drug enforcement. None of the plans works very well. Think about Mexican immigration, the postal service, and Amtrak.

Can any physician believe that the health planners would have ever permitted the construction of a 160-physician clinic in Marshfield, Wisconsin? Would the health planners have allowed the Mayo Clinic to be built in, of all places, Rochester, Minnesota?

Please spare us from more planning because if the plan doesn't work, there will be another one. In any event, whether we cooperate or not, the planners continue to plan while we continue to practice medicine.

ROBERT A MCCORMICK, MD
Green Bay ■

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Complete literature available on request from Professional Services Dept. PML.

Community Health

PART 2

Planning and implementing a health promotion program

through individual, physician, and community responsibility

TERRY L HANKEY, MD, Waupaca, Wisconsin

HEALTH PROMOTION activities, whether the physician or the individual is responsible, must be scheduled at convenient intervals. Wherever possible, the interval between screenings for a particular disease should be based on the rate of progression of that disease. It should be frequent enough so that a false negative test on one occasion won't result in serious harm, but it should be spaced far enough apart so that a great deal of money isn't wasted by the screening process. For most medical illnesses and screening procedures, chronologic age and some multiple of yearly intervals are most commonly used. Medical statistics have been gathered so that we know the age at which a disease becomes a significant risk problem for the patient population and this age can be selected as the time to begin screening for that disease. In some instances we also know the rate of progression of disease and for those screening procedures which apply we can determine the number of years between successive screenings. For convenience and efficiency, health promotion services tend to group themselves into items which should be performed annually, every two years, or at five-year intervals.

Doctor Hankey is Chairman of the Task Force on Health Screening and Immunization. Reprint requests to: Communications Dept, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701.

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Approved by the Council of the State Medical Society of Wisconsin August 5, 1978.

There are other portions of health maintenance and emotional support which do not lend themselves to arbitrary division by chronologic age. Some of these become significant as an individual makes the transition from one phase of the family life cycle to another. These phases of the family life cycle as described in *Family Development* by Evelyn Mills Du Vall[3] are "engagement, establishing, expectant, child-bearing, preschool, school age, teenage, launching, middle age and aging." At each phase there are specific tasks that the family needs to accomplish and these tasks are thoroughly described by the author. At yearly intervals it is suggested that families be screened for changes in phase of development and when a family is found to be beginning a new phase, appropriate counseling should be offered.

Similarly some things become significant as a person makes the transition between one level of adult maturity to another. This is perhaps best described by Gail Sheehy[4] in her best selling book, *Passages*, which describes the predictable crises of adult life. This author takes adult life and makes valid generalizations from common sense observations which we all have made. She systematically divides adult life into stages similar to the stages that have long been accepted as gospel with regard to child rearing. If physicians, clergymen, and other supporting institutions were able to be more effective in predicting and understanding these phases of adult life, we could

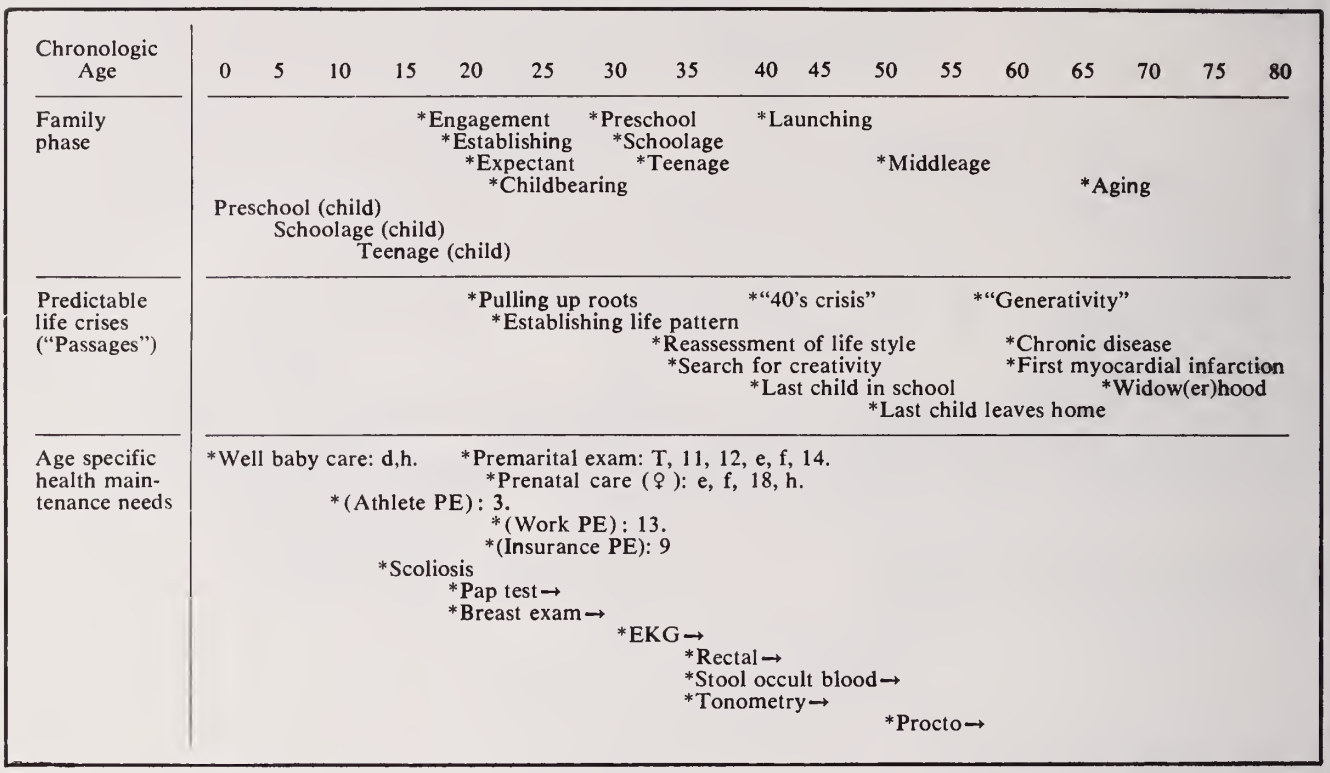

Figure 1—Illustrates how age specific health maintenance needs, which are chronologically based, tend to parallel to the predictable life crises and phase of family development.

Table 1—HEALTH INFORMATION: Health maintenance information for which the individual is responsible

* 1. Accident prevention
2. Alcohol information
3. Breast self-examination
* 4. Dental hygiene
* 5. Diet (nutrition, vitamins, fluoride, iron)
* 6. Diet (weight control)
7. Driver's education, auto safety, seat belts
8. Drug information
* 9. Exercise program
10. Family counseling
11. Family planning, contraception
12. Genetic counseling
13. Occupational hazards
*14. Sex education
*15. Signs of cancer
16. Smoking information
*17. Stress reduction
18. Prenatal classes
19. Cardiopulmonary resuscitation
*20. First-aid training
*21. Swimming instructions
*22. Skin self-examination (report suspicious lesions)
*23. Health questionnaire (review health history or review of systems with doctor)
*24. Life enhancement activities

* Continuous lifelong process

more appropriately counsel people and prevent many bad psychological sequelae to what is essentially a normal maturing process. Figure 1 graphically illustrates how age specific health maintenance needs, which are chronologically based, tend to parallel to the predictable life crises and phase of family development.

Table 1 lists items of health information for which the individual is responsible. These are designated by an arabic numeral. The asterisk designates those items which are continuous lifelong processes and not age specific. Table 2 outlines laboratory tests which require doctor's orders or at least a health screening facility. These are illustrated by a small letter. The asterisk here designates optional tests or tests which are reserved for high-risk cases. Table 3 lists items of physical examination and immunization which require a physician, or nurse or paramedical assistant under the direction of a physician. These are designated by capital letters and their interval is denoted. Table 4 is a listing by chronologic age of those age specific health maintenance procedures which should be provided by the individual and the physician at the designated ages.

Table 2—LABORATORY TESTS: Health maintenance screening which requires doctors' orders or health facility

a. Screening panel every five years (Should include): cholesterol
triglyceride
glucose
creatinine or blood urea nitrogen (BUN)
serum glutamic oxaloacetic transaminase (SGOT) or serum glutamic pyruvic transaminase (SGPT)
b. Stool for occult blood (cancer screen) every year after age 35
c. Urinalysis every two years
*d. Ferric chloride (required phenylketonuria [PKU]) newborn
*e. Syphilis (VDRL) (premarital, preemployment, sexually active)
*f. Gonorrhea (GC) culture (premarital, prenatal, sexually active)
*g. Serum lead (child, old housing, low income)
*h. Hemoglobin or hematocrit (infant or pregnant female)
Blood test for anemia
*i. Sickle cell screen (black)
*j. Uric acid (family history)
*k. Mammogram (large breasts, difficult to examine)
*l. Chest x-ray (smoker, exposure to tuberculosis)

*Optional or high-risk cases

Table 3—PHYSICAL EXAMINATION AND IMMUNIZATION: Health maintenance procedures which require a doctor

A. Scoliosis screen	female at 10, 11, 12, 13, 14, 15 years male at 14, 15
B. Blood pressure	3, 4, 5, 6, 8, 10, 12, 14, 15, 16, 17, 18 years; every 2 years after 18
C. Breast exam and BSE instructions	every 2 years after 16
D. Cardiovascular	every 2 years after 30
E. Dental	every 1 year after 3
F. Ear (HEENT)	every 2 years
G. Pelvic exam with Pap smear	every 2 years after 16
H. Rectal	every 2 years after 35
I. Weight check	every 2 years
J. Eye screen	every 5 years
K. Electrocardiogram (EKG)	every 5 years after 30
L. Audiogram	every 5 years
M. Procto	every 2 years after 50
N. Tonometry	every 2 years after 35
O. Diphtheria, pertussis, tetanus (DPT) or tetanus booster (dT)	(DPT) 2, 4, 6, 18 months and 5 years, then (dT) every 10 years
P. Measles, mumps, rubella (MMR)	15 months
Q. Oral polio vaccine (OPV)	2, 4, 6, 18 months and 5 years
R. Rubella immunization	adult females—once (if titers low)
S. Growth assessment	2, 3, 4, 6, 12, 18 months and 2, 3, 4, 5, 6, 8, 10, 12, 14, 15, 16 and 18 years
T. Developmental assessment	birth, 2, 3, 4, 6, 12, and 18 months and 2, 3, 4, 5, 6 years

NOTE: Additional physical examination to be performed as dictated by symptoms on health history at appropriate intervals.

At patient's request (as physician aid in individual's self-help)

- Check skin lesion
- Throat culture for sore throat (to prevent "strep" throat from becoming rheumatic fever)
- Contraception—sterilization (devices, drugs, or advice)
- Source of information on any health-related topic
- Review of Systems or Health Questionnaire
- Rubella skin test prior to pregnancy
- Phase specific counseling or crisis intervention

THE HEALTH PROMOTION Program outlined is recommended after considering several criteria. In order to maintain a consistent, logical method of altering the recommended program, the criteria are outlined for reference. In order to be included in the program, a disease must be significant and preventable, and the procedure must be appropriate.

SIGNIFICANCE

If a disease meets one of the following criteria, it is significant:

(Incidence) over 200 cases/10,000/year
(Prevalence) over 500 cases/10,000
(Morbidity) over 500 days bed rest/10,000/year
over 500 school days lost/10,000/year
over 500 work days lost/10,000/year
over 10 hospital admissions/10,000/year
over 5 hospital admissions/10,000/FP/year
over 3% of all FP hospital admissions
over 10 office visits/FP/year
over 2% of all FP office visits
(Mortality) over 1/10,000/year (for any age group)

(Misc) social problem which frequently causes stress to family or individual
infectious disease significant in the past and currently held in check by immunization
significant for easily identified high-risk groups only
inflicts permanent handicap or crippling pain
required by law

PREVENTABLE

If a disease is *not* ruled out by one of the following, it is preventable:
lacks identifiable latent phase
no appropriate means of preven-

Table 4—SCHEDULE OF AGE SPECIFIC HEALTH MAINTENANCE PROCEDURES

Self (Parent)		*Doctor*
0		D, F, I, T
2 months		D, F, I, O, Q, S, T
3 months		D, F, I, S, T
4 months		D, F, I, O, Q, S, T
6 months		D, F, I, O, S, T
1 year	4, 5*	S, T, h
15 months		P
18 months		D, F, I, O, Q, S, T
2 years	*	D, F, I, S, T, c
3	*	B, S, T
4	*	B, F, I, S, T, c
5	*	B, J, L, S, T, a, h
6	*	B, F, I, S, T, c
7	*	
8	*	B, F, I, S, c
9	*	
10	*	A, B, E, F, I, J, L, S, a, c, h
11	*	E
12	2, 8, 16*	A, B, E, F, I, S, c, h
13	*	E, h
14	*	A, B, E, F, I, S, c, h
15	*	E, J, L, S, a, h
16	3, 7, 11*	B, C, G, E, F, I, O, S, c, h
17	*	B, E, h
18	*	B, C, G, E, F, I, S, c, h
19	*	E, h
20	5, 9, 19*	B, C, G, E, F, I, J, L, a, c, h
21	*	E, h
22	*	B, C, G, E, F, I, c
23	*	E
24	*	B, C, G, E, F, I, c
25	*	E, J, L, a
26	*	B, C, G, E, F, I, O, c
27	*	E
28	*	B, C, G, E, F, I, c
29	*	E
30	17*	B, C, G, D, E, F, I, J, K, L, a, c
31	*	E
32	*	B, C, G, D, E, F, H, I, c
33	*	E
34	*	B, C, G, D, E, F, H, I, c
35	*	E, J, K, a, b, c
36	*	B, C, G, D, E, F, H, I, N, O, b, c
37	*	E, b
38	*	B, C, G, D, E, F, H, I, N, b, c
39	*	E, b
40	*	B, C, G, D, E, F, H, I, J, K, L, N, a, b, c

Self (Parent)		*Doctor*
41	*	E
42	*	B, C, G, D, E, F, H, I, N, b, c
43	*	E, b
44	*	B, C, G, D, E, F, H, I, N, b, c
45	*	E, J, K, L, a, b
46	*	B, C, G, D, E, F, H, I, N, O, b, c
47	*	E, b
48	*	B, C, G, D, E, F, H, I, N, b, c
49	*	E, b
50	*	B, C, G, D, E, F, H, I, J, K, L, M, N, a, b, c
51	*	E, b
52	*	B, C, G, D, E, F, H, I, M, N, b, c
53	*	E, b
54	*	B, C, G, D, E, F, H, I, M, N, b, c
55	*	E, J, K, L, a, b
56	*	B, C, G, D, E, F, H, I, M, N, O, b, c
57	*	E, b
58	*	B, C, G, D, E, F, H, I, M, N, b, c
59	*	E, b
60	*	B, C, G, D, E, F, H, I, J, K, L, M, N, a, b, c
61	*	E, b
62	*	B, C, G, D, E, F, H, I, M, N, b, c
63	*	E, b
64	*	B, C, G, D, E, F, H, I, M, N, b, c
65	*	E, J, K, L, a, b
66	*	B, C, G, D, E, F, H, I, M, N, O, b, c
67	*	E, b
68	*	B, C, G, D, E, F, H, I, M, N, b, c
69	*	E, b
70	*	B, C, G, D, E, F, H, I, J, K, L, M, N, a, b, c
71	*	E, b
72	*	B, C, G, D, E, F, H, I, M, N, b, c
73	*	E, b
74	*	B, C, G, D, E, F, H, I, M, N, b, c
75	*	E, J, K, L, a, b
76	*	B, C, G, D, E, F, H, I, M, N, O, b, c
77	*	E, b
78	*	B, C, G, D, E, F, H, I, M, N, b, c
79	*	E, b
80	*	B, C, G, D, E, F, H, I, J, K, L, M, N, a, b, c

Arabic numbers: Refer to Table 1 for explanation.
Small letters: Refer to Table 2 for explanation.
Capital letters: Refer to Table 3 for explanation.
*Review list of continuing individual health responsibilities (Table 1).

Note:
h at 1, 5, 10, 15 years for male; annually after menarché for female

tion, immunization or treatment
expense of diagnosis or treatment is excessive
procedure for diagnosis or treatment is not acceptable to most patients

APPROPRIATE

If a procedure is *not* ruled out by one of the following, it is appropriate:

high false negative rate
high false positive rate
risk to the patient too great
cost to the patient too great
patient acceptance too low
not yet proven effective

HEALTH PROMOTION RECORD

Name: _____

To use this form in planning a Health Promotion Program, fill in ages for the next decade, fill in appropriate procedures. Then indicate when procedures are due by placing an asterisk (*) in the box. When completed, enter date.

	Age→										
Procedure	Ref #										

ONCE A PROCEDURE is adopted several questions should be answered to determine how the procedure should be implemented.

IMPLEMENTATION

Procedure performed by:
- Physician (MD)
- Registered Nurse (RN)
- Physician Assistant (PA)
- Other _____

Procedure to be done on:
- all
- females only
- pregnant
- males only
- select age groups _____
- high-risk groups _____

Procedures to identify high-risk individual:

_____

What interval:
- once only
- every visit
- every year
- every 2 years
- every 5 years
- other _____

Anticipated long-range benefit:

_____

Estimated cost:

_____

What questions must be added to history form:

_____

_____

_____

_____

_____

RECORDS FOR HEALTH promotion have traditionally been ignored or buried in the medical record amid masses of data related to illnesses. To prevent this the following format is suggested to assist in the planning of an individual health promotion program, and to keep health promotion activities on schedule.

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3. Duvall, Evelyn Mills, PhD: *Family Development,* 4th ed, JB Lippincott Co, Philadelphia, New York, Toronto, 1971.
4. Sheehy, Gail: *Passages: Predictable Crises of Adult Life,* EP Dutton, New York, 1974. ■

PART 1 appeared in the November issue.

The Task Force on Health Screening and Immunization

. . . grew out of a common concern of three agencies: The State Medical Society of Wisconsin, the Wisconsin Department of Public Instruction and its Bureau for Handicapped Children, and the Wisconsin Department of Health and Social Services and its Division of Health, Policy and Planning.

Late in 1975 representatives of these organizations first met to discuss common problems in matters of public health. Since that time, the representatives have met periodically acting as an advisory committee to policymakers in each of the three agencies and the Wisconsin Legislature.

At the 1976 Annual Meeting of the State Medical Society's House of Delegates a resolution introduced by the SMS Section on Public Health and Preventive Medicine was adopted that reaffirmed the Task Force's existence: "That the Secretary of the Department of Health and Social Services be requested to assign staff to work with the State Medical Society and other interested groups to develop statewide standards for immunization and health screening services; and that these same persons be requested to recommend ways to ensure that these services are made more readily available and accessible to everyone in the state."

Representing the State Medical Society on the Task Force are Terry Hankey, MD, Waupaca and Richard Biek, MD, King, and LaVerne Bartel of the SMS staff. The Department of Public Instruction's representatives are Ernest Cooney and Horace K Tenney III, MD of the Bureau for Handicapped Children. Herbert Bostrom of the Bureau of Prevention and Richard Pegg of the Division of Health, Policy and Planning represent the Department of Health and Social Services. Doctor Hankey, author of the accompanying article, is chairman of the Task Force on Health Screening and Immunization. ■

Cancer Column

PREPARED AND SUPPORTED BY THE WISCONSIN CLINICAL CANCER CENTER IN COLLABORATION WITH THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS COMMITTEE ON CANCER

Cancer epidemiology—PART VI

Hodgkin's disease

HODGKIN'S DISEASE is the most common malignancy of young adults and the most common lymphoma of any age group. It has a bimodal age incidence curve, with an apparent break at about age 40. The sex ratio is close to unity.[1] For younger patients, the disease is usually localized, and the prognosis more favorable than for older patients. The epidemiologic and clinical pattern is more typical of a chronic infection than a malignancy. Older patients have more disseminated disease at diagnosis and a poorer prognosis. The age disparity continues through regional variations. Mortality of elderly US white people is constant, but there is considerable regional variation among the younger group with decreased mortality in the Southeast.[2] In Wisconsin no county has a male mortality rate above the national average, but females in southwest Wisconsin have a higher mortality than expected.[3] Incidence is greater in higher socio-economic groups.

Most epidemiologic studies have been concerned with factors especially related to young adults. An hypothesis suggesting that Hodgkin's disease is caused by a virus (Epstein-Barr virus is most commonly implicated)[4,5] is supported by (1) a clinical picture of relapsing fever, sweating, malaise, leukocytosis, anemia, and a spontaneously remittent course compatible with infection; (2) a histologic picture of dense fibrosis with infiltration of lymphocytes and eosinophils similar to that observed during an infection; (3) geographic variations in mortality, even among relatively homogenous populations;[6] (4) very slight evidence of person-to-person transmission [a 3-fold increase in risk of siblings of Hodgkin's patients and a cluster of cases in a New York high school graduating class[1,7]]; however, persons with a high exposure to Hodgkin's patients such as doctors and nurses show no increased incidence; (5) evidence of time-space clustering, such as seasonal variation in Britain and Germany where more cases occurred at the onset of winter (not corroborated); and (6) laboratory evidence including isolation of EBV virus in tissue from a young man with Hodgkin's and higher anti-EBV titers in Hodgkin's patients than in controls (not confirmed).[8]

Leukemias

Mortality rates for all types of leukemia differ significantly from country to country but not to the extent seen for other cancers. High mortality countries are Scandinavia, Israel, and the United States. Low mortality countries are Japan and Chile. The differences are never more than 2-fold so may merely reflect differences in case detection. The low incidence in Japan is due to the rarity of chronic lymphocytic leukemia.[9] Throughout the world incidence of leukemia has markedly increased since the early 1900s, reflecting improvement in detection and possibly an increase due to environmental leukemogens. In Wisconsin, Rock, Walworth, Jefferson, Dodge, Columbia, Ozaukee, Washington, Green Lake, and Milwaukee counties have a higher mortality rate for white males than the national average, while Wausau, Adams, Juneau, Jackson, and Marquette counties have high mortality rate for white females.

Age and sex differ markedly among different cell types. Acute lymphocytic leukemia is common in children and infrequent in adults. Acute granulocytic and monocytic leukemias are rare in children but account for most adult acute leukemia cases. Acute leukemias affect males and females equally. Chronic lymphocytic leukemia is rare in young adults but common after the age of 50, affecting men twice as often as women. Chronic granulocytic leukemia occurs in all ages, but is most common after 40.[10]

Cancer Column correspondence should be directed to: Dr Paul C Tracy, Wisconsin Clinical Cancer Center, 1900 University Ave, Madison, Wis 53705; or Dr John K Scott, Chairman SMS Committee on Cancer, Box 1109, Madison, Wis 53701. *Cancer Column* is supported by NCI Grant No. 5 R18-CA-16405-03. Copyright 1978 by the State Medical Society of Wisconsin.

Incidence of leukemia has a peak at ages 2 to 5 (5/100,000), falls in young adults (2-4/100,000), and increases for people over 50(20-30/100,000).[11] The early peak which began to develop in the 1920s in England but was not seen in the US whites until the 1940s is not usual for other malignancies.[12] It is now beginning to appear in Japan and in nonwhites in the US, suggesting environmental factors or an infectious disease.

The ability of irradiation to produce leukemia is well established. The first evidence was obtained from death notices in *JAMA* where the frequency of leukemia among radiologists was observed to be more than eight times that of other physicians. The most compelling evidence for the etiologic role of radiation came from studies of atomic bomb survivors in Japan.[13,14] Incidence of all types of leukemia except chronic lymphocytic leukemia began to increase 1-½ years after the explosion, reached a peak in 1951-2, then declined gradually. With therapeutic radiation, leukemia incidence is higher in men treated for ankylosing spondylitis,[15] children treated for thymic enlargement, and patients irradiated for polycythemia vera and metropathia hemorrhagica.[16] No increase was noted in those irradiated for hyperthyroidism or cervical cancer,[17] perhaps due to variations in dose, sites irradiated, or type of radiation used.[18] Most studies of low dose radiation used for diagnostic purposes show a small increase in childhood leukemia following prenatal x-ray exposure.[19]

Little epidemiologic evidence exists concerning chemical leukemogenesis.[20] Individual case reports have suggested an association with benzene, phenylbutazone, chloramphenicol, melphalan, LSD, and chlorambucil. Leukemia mortality is slightly increased among rubber workers and farmers who are exposed to environmental chemicals.[21,22] Dietary fat may be a factor.

Genetic factors may contribute to leukemia etiology. There have been conflicting reports of clustering of leukemia in families. Studies of twins suggest an association, but it is hard to separate genetic and environmental factors.[23] The concept of leukemia as a genetic disease is supported by chromosomal abberrations (*ie,* Philadelphia chromosome in chronic granulocytic leukemia)[24] and the 20 times greater than normal incidence of leukemia with Down's syndrome (Trisomy 21).[25,26] Leukemia develops more frequently in people with coronary heart disease.

Animal studies indicate that viruses play a central role in cancer etiology, but epidemiologic evidence that infectious agents contribute to leukemia is scanty.[27] Attempts have been made to demonstrate a relationship between leukemia onset and an antecedent or co-existent infection (measles, chicken pox, mumps, or infectious mononucleosis). An English study of perinatal infections suggest that risk of leukemia is significantly increased in children whose mothers had influenza during pregnancy. Efforts to show direct contact between cases have been largely unsuccessful. Studies of clustering of leukemia cases have been variable. No seasonal pattern has been found. Conflicting results have been obtained regarding transmission by blood transfusions or immunizations. Patients with leukemia have a significant increase in the risk of other cancers. The largest excess of second primaries occurs with skin cancer (up to nine times).

(References can be obtained upon request to the Wisconsin Clinical Cancer Center.)

—Jane Harberg
Dorothy J Buchanan-Davidson, PhD

Mark your calendar!

. . . for the Wisconsin Clinical Cancer Center Special Dedication Week Program, Wednesday, Feb 21, 1979. Special guest: Charles Moertel, MD, Mayo Clinic, Rochester, Minn. ■

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Organizational SMS

New regulation deals with access for handicapped

The Department of Health, Education, and Welfare has issued much disputed regulations regarding the rights of physically or mentally disabled persons to services and jobs wherever HEW federal funds, services, or property are involved. These regulations implement Section 504 of the Rehabilitation Act of 1973 and will be subject to considerable interpretation in the coming months. They define and forbid acts of discrimination against "qualified" handicapped individuals in employment, as well as in the operation of programs and services.

Providers of services must ensure that their programs are operated in facilities that are readily accessible to handicapped individuals, that all new facilities constructed be accessible to handicapped individuals, and the programs operated in such facilities are operated in a nondiscriminatory manner.

As it stands now, the Bureau of Health Care Financing has determined "federal funding" includes those services which are provided by a physician involving Medicaid or Medicare reimbursement. However, a court case is pending which may limit the regulation's applicability to services provided for under Medicaid. If you are a private physician serving patients who are beneficiaries of either service you must, according to HEW:

- Have an office physically accessible to handicapped patients, or
- Treat handicapped patients in a hospital or at home, or if this is not possible, and you have fewer than 15 employees,
- Refer them to another physician whose office is accessible, after consulting with the handicapped persons.

According to HEW, administrators of a health care or social service facility (such as clinic managers) are required under Section 504 regulation to:

- Evaluate the quality and availability of services to handicapped persons and begin to correct inequitable policies or practices.
- Make the evaluation with the assistance and expertise of disabled persons.

Physicians' offices and clinics are *not* required to provide ramps, elevators, and other devices to remove physical barriers in *every* part of a single building or in every building, according to the regulation. However, they are required to:

- Make every program or service, *viewed as a whole,* accessible to handicapped persons—be they mobility impaired, blind, deaf, afflicted with alcoholism or drugs, etc.
- Make structural changes where needed in existing buildings to provide access to services or programs or provide such alternatives as home visits or relocation of programs to accessible sites.
- Design new buildings to be barrier free. Barrier free access for disabled persons must be provided in all buildings where construction began on or after June 3, 1977, the effective date of HEW's Section 504 regulation.

To date, state agencies have not complied with Section 504, and much interpretation needs to be done before enforcement is possible. Physicians wishing more information on Section 504 should contact Neal Neuberger at SMS Health Services Division in Madison. ■

Call for scientific exhibits for 1979 Annual Meeting

The SMS Commission on Continuing Medical Education is desirous of knowing at this time which members of the State Medical Society are interested in exhibiting at the May 10-12, 1979 Annual Meeting to be held at MECCA in Milwaukec.

Since there is a time limit on acceptance of applications, physicians may secure the application form by contacting Arlene K Meyer of the Health Services Division of the State Medical Society: (toll-free) 1-800-362-9080. ■

Health Planning Commission continues its work

The SMS Health Planning Commission met at Society headquarters in Madison November 16. At that meeting the Commission:

- Endorsed a recommendation by the Wisconsin Health Systems Agencies to HEW for a one-year extension for implementing the National Guidelines for Health Planning.
- Recommended 12 physicians for membership on the General Advisory Committee on the decertification of specialized hospital services to the Bureau of Needs Review.
- Voted to hold an educational seminar on health planning for physicians in June 1979. The seminar will cover such topics as: an overview of the general economic scene, analysis of the rise in health-care costs, a discussion of the surge in health-care costs in Wisconsin, legislative health planning mandates, implementation of federal health planning goals in Wisconsin, and increasing physician participation in health planning.
- Recommended to the SMS Governmental Affairs Commission that it support the Community Public Health Services Act which purports to revamp the public health delivery system in Wisconsin—bringing the public health system in line with other human service delivery systems in Wisconsin.
- Recommended that officials from St Luke's Hospital in Racine and St Catherine's Hospital in Kenosha meet with the Southeastern Wisconsin Health Systems Agency to develop a plan to deliver cobalt treatment in a more effective manner, and at lower cost. ■

Unified membership poll underway

The State Medical Society this month is conducting an opinion poll of all Wisconsin licensed physicians on the question of "unified membership" in the county, state medical societies, and the American Medical Association. The poll was directed by the Council and its results will be taken under advisement by the Council in its future planning. All physicians (both members and nonmembers) have been mailed materials outlining the pros and cons of unified membership, along with a postcard for physicians to indicate their position on the issue.

Currently in Wisconsin, a physician who wants to be a medical society member must join the county, state, and national medical organizations. Without a unified membership rule, physicians could join all three groups as one option, or the county-state societies as another option. The State Medical Society of Wisconsin was created by the Wisconsin Legislature and county medical societies exist by charter from the State Medical Society, thus state and county membership cannot be divided.

The issue of unified membership has been presented to the SMS House of Delegates for a number of years, with the debate reflecting about a 50-50 split of membership. Since the poll includes nonmembers, a broader scope of physicians' views is anticipated.

Thousands of physicians have already returned their responses. All responses must be returned to SMS no later than Dec. 20, 1978. Physicians are urged to take part in the poll since only with a high rate of return will the poll's results be significant. A report will be made to the Council in January 1979 on the opinion poll's results. MEDIGRAM will carry a story on these results at that time. ■

Two new staff members join SMS

The State Medical Society of Wisconsin announced the appointments of two new staff members in November. Donald Lord joined the SMS Physicians Alliance staff November 20 as a legislative coordinator, filling the vacancy created by the departure of Mark Mendelson.

The Society also will welcome back in January William Wendle who will assume the position of Scientific Affairs Coordinator for the SMS Health Services Division. From 1974 to May 1978, Bill served as Continuing Medical Education Coordinator for the Society. For the past eight months he has been the Health Planning Director for the Wisconsin Hospital Association.

Lord served as an analyst for the Assembly GOP caucas staff from 1975 to 1977 and most recently was employed by the Department of Health and Social Services in the Division of Management Services. ■

Dues statements mailed

This month all SMS physicians received their 1979 dues statements for State Medical Society of Wisconsin, county medical society, and American Medical Association membership renewals.

As approved by the SMS House of Delegates, the dues for 1979 will be $320 for SMS membership, $250 for AMA membership, plus individual county medical society dues.

SMS President Jules D Levin, MD is urging all physicians to renew their support of the federation of organized medicine.

"It has been a year of change and development for the State Medical Society of Wisconsin," Levin said. "Society physicians are taking part in the formulation of health planning strategy at the state and local levels, are providing health education services to their communities, are speaking out in the press on issues facing medicine today, and are keeping "tabs" on government and its ever-increasing numbers of directives and regulations concerning medical care in Wisconsin."

"In order to insure a promising future for medicine and quality care for patients physicians must work together through the federation of organized medicine," Levin commented. ■

Dr Schmidt elected president of SMS Services, Inc

The State Medical Society's newest entity, SMS Services, Inc, a for-profit corporation established to concentrate on serving the business and personal interests of physicians' practices, has announced the following directors and officers elected by the Council:

Daniel K Schmidt, MD, Milwaukee, president; John P Mullooly, MD, Milwaukee, vice-president; William P Crowley Jr, MD, Madison, treasurer; and Earl R Thayer, Madison, secretary; Timothy O Flaherty, MD, Neenah; Paul G LaBissoniere, MD, Wauwatosa; Russell F Lewis, MD, Marshfield; Duane W Taebel, MD, LaCrosse; and Allen O Tuftee, MD, Beloit.

Authorized by the SMS House of Delegates in April and approved by the Council October 28, the new corporation assumed immediate operation of existing programs such as group insurance programs, sponsored services, seminars, and tours.

SMS Services, Inc looks to the future development of new programs in such areas as practice management consultation services, seminars for physicians' office personnel, records retention, a business insurance package, and selected offerings for the purchase of office and medical equipment at advantageous prices.

All shares of the new corporation are owned by the State Medical Society of Wisconsin and will be voted, as a unit, by the Council. Bylaws provide that at least six of its nine directors must be SMS members in good standing.

It is expected that SMS Services, Inc, while expanding services to Society members, will, in the long term, generate income which will reduce the Society's expenses. Further announcements and new programs will be forthcoming shortly on SMS Services, Inc letterhead. Watch for them! ■

Watch for T-19 bulletin in coming weeks

The long awaited final draft of the Medical Assistance Super-Rule has been released by the Wisconsin Department of Health and Social Services. The rule has been transmitted to standing committees of the Legislature for review, and public hearings on the Super-Rule took place in late November and early December. At these hearings the State Medical Society and the "Health Care Coalition" presented testimony regarding the impact of the rule. In order to keep SMS members informed of current developments and activities concerning the Super-Rule, a special insert entitled "T-19 Update" will be included in several issues of MEDIGRAM during the coming weeks. Watch for it. ■

MEMBERSHIP REPORT

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership Report as of Oct 20, 1978

NEW MEMBERS

Key: (Date of birth, membership classification; specialty/sub-specialty)

County Medical Society

DANE

Ajir, M Farroukh, 1300 University Ave, Madison 53706 (1949, Resident, Neurological Surgery)

KENOSHA

Knight, Raymond W, 6530 Sheridan, Kenosha 53140 (1944, Regular, Internal Medicine/Hematology)

MARATHON

Delaplaine, Richard, 1100 Lake View Dr, Wausau 54401 (1924, Regular, Psychiatry, Certified)
Tiangco, Ernest P, 1100 Lakeview Dr, Wausau 54401 (1929, Regular, Psychiatry/Psychosomatic Medicine)

MILWAUKEE

Davis, Jeffrey P, 1300 W North Ave, Milwaukee 53005 (1946, Resident, Ophthalmology)
Dorman, David K, 2323 N Mayfair Rd, Milwaukee 53226 (1942, Regular, Plastic Surgery)
Gopal, Kandavar M, 2014 S 102nd St, Milwaukee 53227 (1946, Resident, Physical Medicine and Rehabilitation)
Gupta, Ravi, 7712 W Burleigh St, Milwaukee 53222 (1948, Regular, General Practice/Internal Medicine)
Heber, David L, 3524 N 64th St, Milwaukee 53216 (1946, Regular, General Surgery).
Herszenson, Sidney, 6806 N Reynard Rd, Milwaukee 53217 (1947, Regular, Dermatology)
Jordon, Robert E, 5000 W National Ave, Wood 53193 (1938, Regular, Dermatology, Certified)
Laporta, Anthony J, 9721 N Lake Dr, Bayside 53217 (1947, Resident, General Surgery)
Linde, John W, 3211 S Ventura Dr, New Berlin 53151 (1941, Resident, Ophthalmology)
Messer, Peter W, 2341 W Appleton Rd, Milwaukee 53209 (1947, Regular, Dermatology)
Woods, James H, 2300 N Mayfair Rd, Milwaukee 53226 (1943, Regular, General Surgery/Cardiovascular, Certified-GS)
Wu, Hui Tien, 8541 N Pelham Parkway, Bayside 53217 (1938, Regular, Obstetrics and Gynecology/Endocrinology)

MONROE

Ahn, Helen H, 325 Butts Ave, Tomah 54660 (1942, Regular, Pathology)
Narasimhan, K M, 315 W Oak St, Sparta 54656 (1946, Regular, General Surgery, Certified)

OUTAGAMIE

Merrick, James G, 401 Oneida St, Appleton 54911 (1949, Regular, Pediatrics)

WASHINGTON

Gardner, Robert J, 844 W Badger Lane, West Bend 53095 (1924, Regular, General Surgery/Thoracic Surgery, Certified-GS.)
Lewis, Joseph D, 279 S 17th Ave, West Bend 53095 (1937, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)

WOOD

Baldauf, Mary C, 1000 N Oak Ave, Marshfield 54449 (1949, Regular, Pathology, Certified)
Blaha, J David, 1000 N Oak Ave, Marshfield 54449 (1947, Regular, Orthopedic Surgery)
Cantillo, Roberto, 1000 N Oak Ave, Marshfield 54449 (1946, Regular, Internal Medicine, Certified)
Errico, Charles A, 913 W State St, Marshfield 54449 (1942, Regular, Ophthalmology)
Freedman, Peter M, 1136 W Blodgett St, Marshfield 54449 (1945, Regular, Allergy/Internal Medicine, Certified-A)
Fye, W Bruce, 1000 N Oak Ave, Marshfield 54449 (1946, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)
Maby, Sharon L, 1000 N Oak Ave, Marshfield 54449 (1946, Regular, Pediatrics, Certified)
Seelen, Michael C, 1000 N Oak Ave, Marshfield 54449 (1944, Regular, Urology)

CHANGE OF ADDRESS

(Does not include those within a city)

DANE

Hank, George C, Madison, to 1337 Chicago Dr, Friendship 53934

LANGLADE

Curran, William P, Deerbrook, to 2821 SW 4th St, Boynton Beach, FL 33435

MARATHON

Prehan, Fred C, Wausau, to 9 High Point Circle, Naples, FL 33940

MILWAUKEE

Kalb, Clifford H, Milwaukee, to Mockingbird Hill, Landrum, SC 29356
O'Brien, Marilyn J, Caldonia, to 1108 E Kensington Pl, Arlington Heights, IL 60004
Solanki, Kirit V, Milwaukee, to 217 Westwood Ave, Victoria, TX 77901

SHAWANO

Heyl, Peter S, Shawano, to PO Box 121, Newfields, NH 03856

SHEBOYGAN

Gascoigne, C C, Madison, to 4210 Ironwood Circle, Bradenton, FL 33505
Gutowski, Franz, Plymouth, to PO Box 674, Tucumcari, NM 88401
Johnson, Rodney C, Sheboygan, to Dept of State USA, M/Med Rm 2906, Washington DC 20520

WOOD

Dhru, Dhavalkirit S, Marshfield, to 200 15th Ave, East, Seattle, WA 98112
Horvath, Edward P Jr, Marshfield, to 3333 Vine St, Cincinnati, OH 45220

DEATHS

Verdone, Anthony J, Milwaukee County, Aug 7, 1978
Albright, Howard, Milwaukee County, Sept 14, 1978
Squier, Theodore L, Milwaukee County, Sept 30, 1978
Helmbrecht, Milan G, Walworth County, Oct 7, 1978
Thomson, Douglas E, Eau Claire-Dunn-Pepin County, Oct 9, 1978 ■

OBITUARIES

◈ County, State, AMA Members

Sean B Lydon, MB, Wauwatosa, died July 28, 1978 in Wauwatosa. He had been an associate professor radiology at the University of Illinois, Chicago, and also was former chief of gastrointestinal radiology at the VA Hospital in Wood. Surviving are his widow, Mary; a daughter, Katherine, and a son, Rory.

◈ **Anthony J Verdone, MD,** 64, Deerfield Beach, Fla, died Aug 7, 1978 in Pompano Beach, Fla. Born Nov 20, 1913 in New York, Doctor Verdone graduated from Marquette University School of Medicine in 1939, and practiced in Milwaukee until his retirement in 1977. He served as chief of staff of Nicolet Hospital and also was chairman of the Department of General Practice at St Michael Hospital in the 1950s.

Surviving are his widow, Helen; and a stepson, John Nicoud, West Chicago, Ill.

◈ **Richard J Muenzner, Jr, MD,** 66, Milwaukee ophthalmologist, died Aug 27, 1978 in River Hills. Born Jan 31, 1912 in Vienna, Austria, Doctor Muenzner graduated from Temple University Medical School, Philadelphia, in 1938. He served in the United States Army Medical Corps from 1940-1946. Surviving are his widow, Doris, and a daughter Daphne (Thatch) Dilley, Madison.

◈ **Victor J Wong, MD,** 69, Milwaukee, died Sept 9, 1978 in Monroe. Born July 22, 1909 in Blanchardville, Doctor Wong graduated from the University of Louisville Medical School in 1938. He practiced internal medicine in

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Milwaukee from 1944 until his retirement in 1977. He also was chief of staff of Main Medical Services at Allis Chalmers. Surviving is his widow, Dorothea, Milwaukee.

◈ **Roland S Cron, MD,** 86, Glendale, died Sept 12, 1978 in Milwaukee. Born May 19, 1892 in Manistee, Mich, Doctor Cron graduated from the University of Michigan Medical School in 1917. He was founder and first president of the Wisconsin Obstetrical and Gynecological Society; founder and first president of the Milwaukee Gynecological Society; and also served as president of the Milwaukee Surgical Society. From 1931-1961, Doctor Cron served as clinical professor and chairman of the department of obstetrics and gynecology at Marquette University School of Medicine, now the Medical College of Wisconsin.

Surviving are his widow, Florence; a son, James, Milwaukee; and a daughter, Mrs Louis (Judi) Friedman of Canton, Conn.

◈ **Howard Albright, MD,** 52, Milwaukee, died Sept 14, 1978 in Waverly, New York. Born Mar 19, 1926 in Sayre, Pennsylvania, Doctor Albright graduated from New York State College of Medicine, Syracuse, New York. He was a member of the medical staffs of Milwaukee Lutheran, Columbia, and St Mary's hospitals. Before his retirement from private practice in 1974, Doctor Albright also had been an associate professor of preventive medicine at the Medical College of Wisconsin. Surviving are his widow, Olive; five daughters, Mary Michel and Jane Stover, St Paul, Minn; Jennifer, Birmingham, Ala; and Deborah and Carol both of Mequon; three sons, John, Quigg, and Matthew of Mequon.

◈ **James E Miller, MD,** 68, Madison, died Sept 14, 1978 while traveling in Hong Kong. Born July 1, 1910 in Milwaukee, Doctor Miller graduated from the University of Wisconsin Medical School in 1938. He served in the United States Army Medical Corps from 1941-1945. He was a clinical professor in orthopedic surgery at the University of Wisconsin, Madison, and also served as president of the Wisconsin Orthopedic Society. He retired from medical practice in 1945. Surviving are his widow, Josephine; a son, Dr James R, Beloit; and two daughters, Mrs B James (Mary) Neuhauser, Madison, and Mrs S Andrew (Katherine) Kolliner of Philadelphia, Pa.

◈ **Louis H Gueldner, MD,** 67, Fort Atkinson physician for 32 years, died Sept 18, 1978 in Fort Atkinson. Born June 5, 1911 in Milwaukee, Doctor Gueldner graduated from Marquette University School of Medicine in 1936. He practiced medicine in Fort Atkinson from 1937 until his retirement in 1969. He also served in the United States Army Medical Corps during World War II. Doctor Gueldner served as chief of

staff of Fort Atkinson Memorial Hospital and also as chief of surgery.

Surviving are his widow, Mildred; two sons, Dr Terry L Gueldner, Manitowoc, and Gregory P Gueldner, St Paul, Minn; and a daughter, Mrs Gary (Liane) Hevey, Whitefish Bay.

◈ **John J Simones, MD**, 71, LaCrosse, died Sept 18, 1978 in LaCrosse. Born July 7, 1907 in Dubuque, Iowa, Doctor Simones graduated from the University of Iowa Medical School in 1934. He began his medical practice in LaCrosse in 1939 and retired in 1973. Surviving are two sons, J Paul and Bruce, both of LaCrosse.

◈ **Theodore L Squier, MD,** 85, Milwaukee, died Sept 30, 1978 in Milwaukee. Born Aug 21, 1893 in Battle Creek, Mich, Doctor Squier graduated from the University of Michigan Medical School in 1919. He was a former associate clinical professor at Marquette University Medical School (now The Medical College of Wisconsin) and also was on the medical staffs of Columbia and Milwaukee County General hospitals. Doctor Squier served as president of the American Academy of Allergy in 1950. He is survived by three sons, Theodore L, Jr, McLean, Va, John, Fox Point and Charles of Boulder, Colo.

◈ **Walter A Werner, MD,** 82, Stoughton, died Oct 12, 1978 in Madison. Born May 10, 1896 in Wisconsin Dells, Doctor Werner graduated from the University of Wisconsin Medical School, Madison, in 1942, practiced medicine in Nekoosa for five years, and then entered the field of Public Health. He retired in 1966. Surviving are his widow, Edith; three daughters, Mrs Raymond Sunderland, Mosinee; Mrs William Turner, Houston, Tex, and Dr Joan Werner, Madison ■

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1978

1 WisPRO Criteria Committee
1 Health Care Coalition
2 WisPRO Review and Evaluation Committee
2 Ancillary Service Review Committee
6 Dane County Medical Society HMP Committee
7 Dane County Medical Society Board of Trustees
8 SMS Committee on Federal Legislation
8 SMS Committee on Governmental Affairs
8 SMS Committee on Environmental Health
8 SMS Section on Ophthalmology
8 Dane County Medical Society Board of Trustees Ad Hoc Committee
8 *SMS Services, Inc, Board of Directors (Madison)*
9 WHCR1 Board of Directors
9 SMS Commission on Peer Review
13 Madison Society of OB-GYN
15 WisPRO Advisory Group
16 Wisconsin Council of Professions
16 SMS Commission on Health Planning
17 SMS Maternal Mortality Study Committee
17 SMS Committee on Maternal and Child Health
17 Title 19 Oversight Committee
18 *AMA Delegation Caucus (Milwaukee)*
20 Health Care Coalition
28 SMS Committee on Aging and Extended Care Facilities
28 Medical Audit Committee
28 *Executive Committees of SMS Council, Wisconsin Review Foundation, and WisPRO (Milwaukee)*
29 WisPRO Executive Committee and Board of Control
29 Dane County Medical Society Board of Trustees Executive Committee
29 Dane County Medical Society Board of Trustees Ad Hoc Committee
30 Nutrition Advisory Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in Italic with the location in parenthesis.

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Physician Briefs

* PHYSICIAN MEMBERS OF STATE MEDICAL SOCIETY OF WISCONSIN

Donald P Pinkel, MD
. . . Milwaukee, professor and chairman of the Department of Pediatrics at the Medical College of Wisconsin, recently became chairman of pediatrics at the City of Hope National Medical Center, Duarte, Calif. Doctor Pinkel, one of the leading experts on leukemia and other childhood cancers, came to Milwaukee in 1974. He started the Midwest Childhood Cancer Center at Milwaukee Children's Hospital.

Dennis M Korger, MD
. . . recently joined the Deckner Medical Center, Green Bay, in the Department of Pediatrics. A 1970 graduate of the Medical College of Wisconsin, Doctor Korger completed his internship and residency at the University of Southern California, Los Angeles County Medical Center. He previously had been in private practice in Astoria, Ore.

James E Lockey, MD
. . . recently became associated with the Manitowoc Clinic. He received his medical degree from Temple University Medical School, Philadelphia, Pa, in 1972. He served his internship and residency at the University of Minnesota Hospital in Minneapolis. In 1975 he received the American Lung Association Fellowship Grant and in 1978 completed a two year research fellowship in pulmonary medicine in the University of Minnesota Hospital.

Uday V Gupte, MD
. . . recently became associated with the Hartford Clinic, SC. Doctor Gupte graduated from Topiwala National Medical College, India, and did his residency training at the French and Polyclinic Medical School and Health Center, New York. Prior to joining the Clinic, Doctor Gupte had been at the Jewish Hospital and Medical Center of Brooklyn and also had practiced at the Lincoln Hospital in Brooklyn, NY.

James C Opitz, MD*
Stephen Wagner, MD*
. . . recently participated in the "Ashland Campus of Wisconsin Indianhead Technical Institute's" program of 'Mothers and Infants at Risk,' a program for professionals who provide maternal, infant and family care. The regional program of continuing education is cosponsored by the North Central Wisconsin Perinatal Center, St Joseph's Hospital, and Marshfield Clinic. Doctor Opitz's topic was entitled "Infant Feeding Techniques" and Doctor Wagner's topic was entitled "Crisis Intervention With The Family of a Child With Birth Defects." Doctor Opitz is a neonatologist with the Marshfield Clinic and Doctor Wagner is a pediatrician with the Clinic.

Jacob Lemann Jr, MD*
. . . Milwaukee, recently was the recipient of the Milwaukee Academy of Medicine's Distinguished Physician Award. He is professor of medicine, director of Clinical Research Center and chief of the Nephrology Section, Medical College of Wisconsin. He was the guest speaker at the monthly meeting of the Academy.

Narayan H Amarnani, MD
. . . Green Bay, recently opened his medical practice in the specialty of gastroenterology. A native of Bombay, India, Doctor Amarnani served his internship and residency training from the Medical College of Ohio, Toledo, and the Medical College of Wisconsin, Milwaukee, respectively.

Stanley B Marshall, MD*
. . . Hollandale, recently was honored by the community for his many years of service to the area. Doctor Marshall will retire January 1 after 45 years of medical practice. He graduated from Loyola University School of Medicine, Chicago, in 1932 and served his internship at St Mary's Hospital in Madison.

Carroll A Bauer, MD*
. . . (left above) received a recognition plaque from Cesar V Sison, MD* on behalf of St Joseph's Community Hospital, West Bend. Doctor Bauer, who had been appointed to the Honorary Staff of the hospital, retired from active practice in June. Doctor Sison is president of the hospital's medical staff.

David J LaFond, MD*
. . . pathologist at Lutheran Hospital, Milwaukee, was installed as president of the American Society of Clinical Pathologists, September 21, during the Joint ASCP-CAP Fall Meeting in St Louis, Mo.

Derward Lepley Jr, MD*
. . . Milwaukee, recently was awarded the "Lutheran Layman of the Year Award for 1978." Doctor Lepley, former chairman of the Department of Surgery at the Medical College of Wisconsin, has been chief of cardiovascular surgery at Milwaukee County General Hospital since 1962. The award is presented annually by the Lutheran Men in America of Wisconsin for outstanding achievement in the religious, humanitarian and civic fields.

John Heffelfinger, MD
. . . pediatrician and mental retardation researcher, recently became the medical director of Bethesda Lutheran Home in Oconomowoc. A graduate of the University of Michigan Medical School, Doctor Heffelfinger has been a faculty member in the Department of Pediatrics at the University of Michigan Medical Center, Ann Arbor; was in private practice in Coldwater, Mich; served on the staff of the Coldwater Community Health Center, and has been a member of the Research and Utilization committees of the Coldwater Regional Center for Developmental Disabilities.

John A Thranow Jr, MD*
. . . recently was elected president of the medical staff of Holy Family Hospital in Manitowoc. He graduated from the University of Wisconsin Medical School, Madison, and has been in general practice in Valders since 1965.

Syed H Akhtar, MD*
Thomas J Karras, MD
. . . Wausau and Madison, respectively, recently were admitted to Fellowship in the American College of Cardiology. The announcement was made by William C Boake, MD, Madison, American College of Cardiology Governor for the state of Wisconsin. ■

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News Highlights

*PHYSICIAN MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

American College of Surgeons

. . . recently held its Sixty-fourth Annual Clinical Congress meeting in San Francisco and the following Wisconsin physicians participated in the program. They are MDs Robert E Condon,* Marvin Glicklich,* Robert J Flemma,* Victor M Bernhard, Glenn A Meyer,* Victor Haughton, John Melvin,* Alfred J Tector,* Jack C Manley,* William E Mateicka,* Jerome J DeCosse,* Frederick J Hofmeister,* Ashok V Kumar, Thomas M O'Connor,* Stephen A Stromstad, Herbert M Kauffman,* Derek Sampson, Sanford J Larson* all from Milwaukee; David G Dibbell,* Folkert O Belzer,* James R Starling,* and Fritz H Bach, Madison; Don G Traul,* Monroe; Duane Tewksbury, David M Lolley,* William O Myers,* Jefferson R Ray III* and Richard D Sautter,* Marshfield.

The Medical College of Wisconsin

. . . has received approval from the American Medical Association for a Family Practice Residency program at Lutheran Hospital of Milwaukee. The MCW Department of Family Practice now has affiliated programs in four Milwaukee area hospitals. These hospitals are St Luke's, St Michael, Deaconess and Lutheran.

Donald J Welter, MD,* Chairman of the Department of Family Practice, said the Family Practice Clinic at Lutheran Hospital will be located in an existing five-story building on the hospital grounds. Necessary remodeling will not be extensive and will be completed before the first group of residents is admitted to the program in July 1979. All correspondence regarding the new program can be directed to Donald J Welter, MD,* Director, or to Glenn A Dall, MD,* Associate Director, Family Practice Residency Program, Lutheran Hospital of Milwaukee, 2200 West Kilbourn Avenue, Milwaukee, Wis 53233.

LaCrosse County Medical Society

. . recently elected David E Goodnough, MD* as the president-elect for 1979. He will succeed James T Murphy, MD,* LaCrosse, who is presently president. Doctor Goodnough has been a member of the Gundersen Clinic medical staff since 1966. He is a director of the Western Wisconsin Health Systems Agency.

Wisconsin Society of Internal Medicine

. . . recently installed John P Mullooly, MD* as its president for 1978-79. He has served as the Society's secretary-treasurer and for two years as chairman of the scientific program committee. He also served on the society's membership, medical practice and legislative committee. He has been a delegate to the American Society of Internal Medicine for the past three years. Doctor Mullooly was elected to the WSIM governing council in 1973. Michael J Mally, MD,* Hartford, was named president-elect. He was the society's secretary-treasurer last year and is currently a delegate to the ASIM. Others elected were MDs Kenneth I Gold,* Beloit, secretary-treasurer and Anthony P Ziebert,* Milwaukee, to a three year term on the governing council.

Wisconsin Society of Otolaryngology

. . . has named Larry Severeid, MD,* LaCrosse, as the president-elect for 1978-79. Doctor Severeid, staff physician with the Gundersen Clinic since 1971, is director of the Cleft Palate and Craniofacial Deformity Clinic. He also is on the national committees of the American Society of Facial Plastic and Reconstructive Surgery and is a member of the continuing education task force of the American Academy of Ophthalmology and Otolaryngology.

Life Physicians

. . . an organization of Wisconsin physicians and medical students dedicated to the prolife cause has been formed by the Wisconsin Citizens Concerned for Life (WCCL). With education as their primary purpose, Life Physicians hope to make other physicians, medical students, social workers and the public aware of alternatives to abortion, infanticide, and euthanasia. Life Physicians will serve in an advisory capacity to the WCCL state and local chapters in medical matters. The group wishes to identify themselves to doctors and their patients as being dedicated to the right to life. The Life Physicians' organization committee's chairman is Parnell Donahue, MD,* Hartford. Other MDs who are members of the committee are John Brennan,* Stan Kenwood,* and John Hartwick,* all of Milwaukee.

St Michael Hospital

. . . Milwaukee, is host to a seminar on depression. Entitled "Depression: Enhance Diagnostic Acumen and Improve Management," the seminar will be held on January 13, from 8:00 am to 12:15 pm at the hospital. The medical staff of St Michael Hospital and the Wisconsin Psychiatric Association are sponsoring the seminar. Speakers will be MDs John J Schwab, University of Louisville; Elliott Richelson, Mayo Medical School; and Richard Abrams, Chicago Medical College. Doctor Schwab will discuss the "Classification of Depressive Disorders." Doctor Richelson will speak on "Neurotransmitters: Drug Interreactions," and Doctor Abrams' topic will be "Biological Treatments of Depression." The seminar also will mark the 20th anniversary of the St Michael Hospital Psychiatric Department.

American College of Radiology

. . . has announced the following new Wisconsin members: Howard H Johnson, MD,* Racine; Thomas A Keller, MD,* Manitowoc; Thomas R Terhorst, MD,* LaCrosse; Ray M Thorpe, MD,* Scofield, and Bhudatt R Paliwal, MD, Madison.

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NEENAH
729-1311
881 S. Green Bay Rd.

SHOREWOOD
961-2000
4081 N. Oakland
Milwaukee

THIENSVILLE
242-3450
Bonnywell Village
278 N. Main St.

MILWAUKEE
464-4600
7713 W. Capitol Dr.

FOND DU LAC
921-5262
88 Forest Ave.

NEW BERLIN
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Rogers Memorial Hospital

. . . in Oconomowoc had its Hospice program featured in Dr Elizabeth Kubler-Ross' latest book, *To Live Until We Say Goodbye*. Dr Kubler-Ross, world renowned expert in the field of death and dying, has written this book in collaboration with photographer Mal Warshaw to demonstrate the important, positive effects of her work with dying patients.

The Hospice at Rogers Hospital is discussed in the concluding section of the book which deals with alternatives to hospital care. Dr Kubler-Ross urges that the dying be cared for at home whenever possible, or in hospices devoted exclusively to the care of the terminally ill. Dr Kubler-Ross has included photographs of the Rogers patients and staff, and points out not only the important humane aspects of hospice care but also the fact that this type of program costs much less than traditional hospital services.

This book provides an intimate look at the dying process as experienced by some of Dr Kubler-Ross' patients.

St Joseph's Hospital

. . . in Marshfield dedicated its 336-bed addition on November 5. An open house and public tours were conducted the previous weekend. David R Jaye Jr, hospital president, commented that "the new addition will provide many of the facilities for both personal and professional care of the patient. The completion of the structure is one more example of how the Sisters of the Sorrowful Mother and the Board of Directors of St Joseph's Hospital have continued development of services begun in 1890 when the hospital first opened its doors to the public." Dedication speaker was Sister Mary Caritas Geary, SP, Chairperson, Board of Directors, The Catholic Hospital Association, St Louis. Gerald E Porter, MD,* President, Marshfield Clinic, and Rosemary Sautter (wife of Dr Richard D*), President, Hospital Auxiliary, were among those participating in the dedication program. ■

PEDIATRICS, FAMILY PRACTICE, internal medicine, urology and ENT positions available with a 13-man multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303. Tel: 414/494-5611. 9-12/78

BOARD CERTIFIED, OR BOARD eligible, pediatrician wanted in Wisconsin multispecialty group of 26. College town of 35,000 between Madison, Milwaukee, and Chicago. New clinic building adjacent to new hospital. Very competitive income. Write: W S Freeman, MD, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, Wis 53511. 7-12/78

WANTED: PHYSICIAN TO JOIN multispecialty group practice in Hudson, Wis. a rural community of 8,000 on the St Croix River, 20 minutes from metropolitan Minneapolis-St Paul. The community has an accredited hospital. The clinic newly renovated. Included are guaranteed income, noncontributory profit-sharing plan, opportunity for partnership if desired, liberal fringe benefits. Contact: Diane Stewart, Hudson Clinic, SC, 226 Locust, Hudson, Wis 54016. Tel: 715/386-2311. 2tf/78

INTERNIST WITH AN INTEREST in cardiology. Minneapolis-St Paul internists' group seeks associate who wishes to weight his practice with noninvasive cardiology. Electrocardiography, active coronary care responsibilities, and resident teaching responsibilities in contacts of group practice. Curriculum vitae and references mail to Dept 459 in care of the Journal. 7-12/78

FAMILY PHYSICIAN WANTED TO join group of four which includes three FPs and a general surgeon in lovely Cumberland, Wisconsin, situated on a clean beautiful lake. Clinic adjacent to 47-bed hospital. Salary and benefits negotiable; partnership in one year. Contact: D E Riemer, MD, Cumberland, Wis 54829. Tel: 715/822-2231. 9tfn/78

FAMILY PRACTITIONER, PHYSiatrist and ENT physician needed by 31-man multi-specialty clinic next to 350-bed hospital. Fifty thousand population city in beautiful Mississippi River Valley with sophisticated medicine and excellent cultural attractions. William J O'Leary, MD. 815 South 10th St, LaCrosse, Wis 54601. Tel: 608/782-9760. 7tfn/77

WANTED: FAMILY PRACTICE physician and surgeon to join a group of nine family practitioners, one general internist and one general surgeon in a rural community in northwestern Wisconsin. For additional information, contact Lloyd Cotts, MD, Rice Lake, Wisconsin. Tel: 715/234-9031. 11-12/78

PUBLIC HEALTH COMMISSIONER: City of Racine is seeking a physician with experience in administrative or Public Health medicine to direct the activities of a 40 member City Health Department. This challenging position involves a full range of Public Health activities, including budget and management responsibility, special projects, planning, policy, and staff development. Salary range $36,100-$43,900 commensurate with qualifications and experience. Ideal southeastern Wisconsin location offering excellent recreational activities on beautiful Lake Michigan and only 30 minutes from Medical College of Wisconsin and one hour from the Chicago area. Interested candidates are invited to address their curriculum vitae to James C Kozina, Personnel Director, 730 Washington Ave, Racine, Wis 53403. Affirmative Action Employer. p11-12/78

MEDICAL FACILITIES

FOR SALE: PHYSICIANS SUITE and practice, full-equipped in medical building. Ideal for general practice or internal medicine. 5148 N Teutonia Ave, Milwaukee. Three blocks from St Michael's Hospital. Call Art Smith 414/462-7570 or 414/464-7240, or evenings contact Mrs Duffy 414/352-4469. g5tfn/78

MEDICAL CLINIC SPACE AVAILable. Janesville Road and Pioneer Drive, Muskego. 2,500 sq ft on ground floor. Modern, move-in condition. Please contact: Roger Bothe, John Herschede & Associates, Inc. Tel: 414/933-0585. 7tfn/78

FOND DU LAC FACILITY. COMplete medical practice suite available soon. Suitable for group practice of five or six, or a pair and three. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

FOR SALE: WHIRLPOOL, 30-GAL Ille Mobile type for arm, foot, and lower leg. $600.00. Call 414/342-4144 Monday through Friday, 9:00 am to 5:00 pm. p12/78

BEAUTIFUL MEDICAL BUILDING for lease. 11046 West Bluemound Rd. Milwaukee. 1600 square feet plus 6500 square feet of parking. Everything at ground floor level allowing patients great convenience. Medical equipment, x-ray and furniture available. This building was used only for my practice. Ideal for one or more physicians or dentists, etc. Call 414/774-9022 (11:00 am—2:00 pm) or 414/965-2820, Maurice Greenberg, MD. 6tfn/77

FOR RENT: DESIRABLE SOUTHwest Milwaukee location for group or single practice. New space to individual specifications. Ample parking. Phone: 414/543-7400. 12tfn/78

FOR RENT: OFFICE SPACE available. A new modern medical building. Located southwest side of Milwaukee. X-ray and laboratory facilities available. Close proximity to two hospitals. Call 414/643-4470. 11tfn/78

NEW PROFESSIONAL OFFICE. 1300 sq ft modules for lease in Beaver Dam, Wis. Tel: 414/887-1677. 10-12/78 ■

Bookshelf

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Shadowland by William Arnold. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1978. Pp 260. Price: $9.95.

General Urology by D R Smith, MD, Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1978. Pp 541. Price: $14.50.

Review of Medical Pharmacology by Frederick H Meyers, MD; Ernest Jawetz, MD, PhD; and Alan Goldfien, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1978. Pp 760. Price: $14.50.

Everything You Always Wanted to Know About Nutrition by David Reuben, MD. Simon and Schuster, Rockefeller Center, 1230 Avenue of the Americas, New York, NY 10020. 1978. Pp 287. Price: $9.95.

Current Obstetric and Gynecologic Diagnosis and Treatment by Ralph C Benson, MD. Lange Medical Publications, Drawer L, Los Altos, Calif 94022. 1978. Pp 976. Price: $18.00.

Phosphorus in the Environment: Its Chemistry and Biochemistry. Ciba Foundation Symposium 57. CIBA Pharmaceutical Co, Division of CIBA-Geigy Corp, Summit, NJ 07901. 1978. Pp 320.

The Metabolic Management of the Critically Ill by Douglas W Wilmore, MD. Plenum Medical Book Co, 227 West 17th St, New York, NY 10011. 1978. Pp 262. Price: $22.50. ■

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates:

30¢ per word, with a minimum charge of $12.00 per listing.

BOXED LISTINGS (same type as used in regular listings): $15.00 per column inch.

COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of publication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701.

For listing of other meetings see the Journal of the American Medical Association. Continuing Education Courses for Physicians for period Sept 1, 1977 through Aug 31, 1978 appeared in JAMA (Supplement) Aug 15, 1977.

1979 WISCONSIN

Jan 4-10: Medical College of Wisconsin annual postgraduate course in *Gynecological Pathology, Cytogenetics and Endocrinology*, at Pfister Hotel and Tower, Milwaukee. See details elsewhere in this issue.

Jan 13: *Depression: Enhance Diagnostic Acumen and Improve Management*, St Michael Hospital, Milwaukee. Sponsored by St Michael Hospital medical staff and Wisconsin Psychiatric Association. Info: Karen L Hobl, St Michael Hospital, 2400 West Villard Ave, Milwaukee 53209. Tel: 414/263-8000.

Jan 17-19: 9th Annual Winter Refresher Course for Family Physicians at The Pfister Hotel and Tower, Milwaukee. Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, 610 N 19th St, Milwaukee, Wis 53233. Tel: 414/933-0700.

Jan 18: In-Depth Teaching Program, St Mary's Hospital Medical Center, Madison.

Jan 19: *Diagnostic Ultrasound for the Clinician*, sponsored by the Radiology Department, Madison General Hospital, Madison, WI. A morning symposium approved for 4 hours of Category I CME credit for PRA-AMA. AAFP credit applied for. Faculty: Richard Friday, MD; Robert Corliss, MD; Michael Curtin, MD; William Zweibel, MD; David Atwell, MD; Robert Starshak, MD; James Zegzebski, PhD. Info: Howard Christensen, CME Coordinator, 202 S Park St, Madison 53715. Tel: 608/267-6062

Feb 6-8: 16th Annual Telemark Symposium and Ski Outing, sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians, at Mount Telemark, Cable. Six hours of CME credit, and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove, WI 53122.

Feb 13-14: *Great Lakes Ski-In: Winter Sports Injuries*, East Troy, sponsored by Wisconsin Chapter-American College of Emergency Physicians. Basic CPR course for spouses and children. Fee $80. Info: Contact Wis ACEP, 10201 W Lincoln Ave, Suite #304, Milwaukee, Wis 53227. Tel: 414/545-5568. Eight hours ACEP and AMA Category I credit will be applied for.

Feb 21: In-Depth Teaching Program, Methodist Hospital, Madison.

Mar 15: In-Depth Teaching Program, UW Center for Health Sciences, Madison.

Mar 29-31: 3rd Annual Ophthalmology Current Concepts Seminar. Sponsored by Dept of Ophthalmology Faculty, University Hospitals, Madison; and Davis and Duehr Eye Clinic Staff. Info: Mrs Margaret Kelm, Dept of Ophthalmology, 1300 University Ave, Madison 53706. Tel: 608/262-3835.

May 3-5: Wisconsin Chapter: American Academy of Pediatrics, Pioneer Inn, Oshkosh, Wis 54901.

May 10-12: State Medical Society of Wisconsin Annual Meeting. Marc Plaza, Milwaukee.

May 18-23: American Holistic Medical Association Annual Meeting, at University of Wisconsin, LaCrosse. Cosponsored by The American Society of Contemporary Medicine and Surgery. Forty hours of Category I CME credit. Info: AHMA, Route 2, Welsh Coulee, LaCrosse 54601.

June 22-24: 31st Annual Meeting and Scientific Assembly of Wisconsin Academy of Family Physicians. The Abbey Resort, Fontana, Wis. 15 hours of CME and AAFP Prescribed Credit. Info: WAFP, 850 Elm Grove Rd, Elm Grove 53122.

July 29-Aug 1: The Second Annual *Nuclear Cardiology for the Practicing Physician* at Playboy Club Resort, Lake Geneva, Wis. Info: Dr Jagmeet S Soin, Division of Nuclear Medicine, The Milwaukee County Medical Complex/The Medical College of Wisconsin, 8700 W Wisconsin Ave, Milwaukee, Wis 53226. Tel: 414/257-5968.

1979 NEIGHBORING

Mar 5-8: *Neurology for the Internist*, American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar, ACP, 4200 Pine St, Philadelphia, Pa 19104.

Mar 7-9: Second National Meeting of the Nurses Association of the American College of Obstetricians and Gynecologists, Conrad Hilton Hotel, Chicago.

May 14-18: American Psychiatric Association. Conrad Hilton, Chicago, Ill. Info: M Sabshin, MD, 1700 18th St, NW, Washington, DC 20009.

9th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

Jan 17-19, 1979

The Pfister Hotel and Tower, Milwaukee

Sponsored by the Department of Family Practice, The Medical College of Wisconsin and Southeastern Chapter of the Wisconsin Academy of Family Physicians

Course Director: *Thomas F Garland, MD*, Associate Professor of Family Practice, Program Director, Family Practice Residency Program, Deaconess Hospital

Approved 21 credit hours of CME Category 1 credit by the AMA-PRA

Info: Mrs Susanna Rechlitz, Conference-Manager, Department of Family Practice, 610 North 19th St, Milwaukee, Wis 53233. Tel: 414/933-0700

May 16-18: *Cardiac Auscultation and Cardiac Examination*, American College of Physicians Postgraduate Course, Mayo Clinic, Rochester, Minn. Info: Registrar ACP, 4200 Pine St, Philadelphia, Pa 19104.

1979 OTHERS

Jan 25-27: *National Conference on Forensic Medicine and Society*, sponsored by American Society of Law & Medicine and the Pittsburgh Institute of Legal Medicine, at the Hotel del Coronado, outside San Diego, Calif. Info: ASLM, *Forensic Medicine and Society*, 454 Brookline Ave, Boston, MA 02215.

Mar 4-6: Winter Pediatric Conference, sponsored by Marshfield Clinic Department of Pediatrics, at Powderhorn Ski Lodge, Bessemer, Mich. Info: H James Nickerson, MD, Chairman, Dept of Pediatrics, Marshfield Clinic, Marshfield, Wis 54449.

DIAGNOSTIC ULTRASOUND FOR THE CLINICIAN

Friday, Jan 19, 1979

Bolz Auditorium/Madison General Hospital, Madison

7:45 am	Registration
8:00 am	Physics of Ultrasound, *James Zegzebski, PhD*
8:30 am	Pediatric Ultrasound, *Robert Starshak, MD*
9:00 am	The Gall Bladder, Pancreas and Liver, *David Atwell, MD*
9:30 am	The Kidney and Retroperitoneal Space, *Michael Curtin, MD*
10:00 am	Coffee and rolls
10:15 am	Carotid Imaging and Doppler Ultrasound, *William Zweibel, MD*
10:45 am	Obstetrics, *Richard Friday, MD*
11:15 am	Gyn, *Michael Curtin, MD*
11:35 am	Echocardiography, *Robert Corliss, MD*
12:05 pm	Real Time Ultrasound, *Richard Friday, MD*
12:20 pm	Adjournment

Info: Howard Christensen, CME Coordinator, 202 S Park St, Madson 53715. Tel: 608/267-6062.

Mar 24-28: American Academy of Allergy, Hilton Hotel, New Orleans, La. Info: D L McNeil, Exec Dir, 611 E Wells St, Milwaukee, Wis 53202.

Mar 26-29: American College of Emergency Physicians, Del Monte Hyatt, Monterey, Calif. Info: A Auer, Exec Dir, 3900 Capital City Blvd, Lansing, Mich 48906.

Apr 4-6: American Cancer Society, National Conference - Urologic Cancer, 1979. Los Angeles Hilton Hotel, Los Angeles, CA. Info: Urologic Cancer Conference, American Cancer Society, 777 Third Ave, New York, NY 10017.

Apr 4-6: National Conference on High Blood Pressure Control, The Washington Hilton, Washington, DC. Sponsored by the National High Blood Pressure Education Program Coordinating Committee. Info: Conference Headquarters, NCHBPC, 1501 Wilson Blvd, Suite 600, Arlington, Va 22209; tel 703/527-4500. g9/78-2/79

Apr 26-29: American Society of Internal Medicine, New Orleans, La. Info: W R Ramsey, Exec Dir, 703 Market St, San Francisco, Calif 94103.

18th National Conference on the Detection and Treatment of Breast Cancer

Mar 5-8, 1979 • Atlanta, Ga

Conference devoted to progress in detection and treatment of breast cancer. To feature internationally recognized authorities in the fields of radiology, surgery, pathology, obstetrics and gynecology, epidemiology, and other medical and nonmedical specialties.

Emphasis placed on team approach to cancer management and involvement of various specialties in major problem areas including: high-risk benign disease, minimal breast cancer, radiation risks, detection programs, invasive cancers, the relationship of gynecological disease and breast disease, and rehabilitation.

Sponsored by American College of Radiology. Co-sponsored by College of American Pathologists, Educational Foundation of the Society of Plastic and Reconstructive Surgery, American Academy of Family Physicians, in cooperation with American College of Obstetricians and Gynecologists.

Approved for Category I credit under the AMA continuing medical education criteria.

Further info: American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, MD 20015. Tel: 301/654-6900.

May 13-17: American Urological Association Annual Meeting, New York Hilton, New York. Info: R J Hannigan, Exec Sec, 4640 N Marine, Chicago, Ill 60640.

Nov 1-4: National Perinatal Association Meeting, St Louis, Mo. Contact: Convention Director, National Perinatal Association, 200 East Chestnut St, Louisville, Ky 40202. g9/78

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MILWAUKEE OPHTHALMOLOGICAL SOCIETY

University Club, 924 E Wells St, Milwaukee

1979 Meeting Dates

Jan 23: Retinal Diseases—Fluorescein Angiography—Aids in Diagnosis and Treatment, *Trexler Topping, MD*, Dept of Ophthalmology, Medical College of Wisconsin, Milwaukee, Wis

Feb 24: *Jerry Shields, MD*, Assistant Professor, Wills Eye Hospital, 1601 Spring Garden St, Philadelphia, Penn

Mar 27: *Peter Laibson, MD*, Professor of Ophthalmology, Head, Corneal Unit, Wills Eye Hospital, 1601 Spring Garden St, Philadelphia, Penn

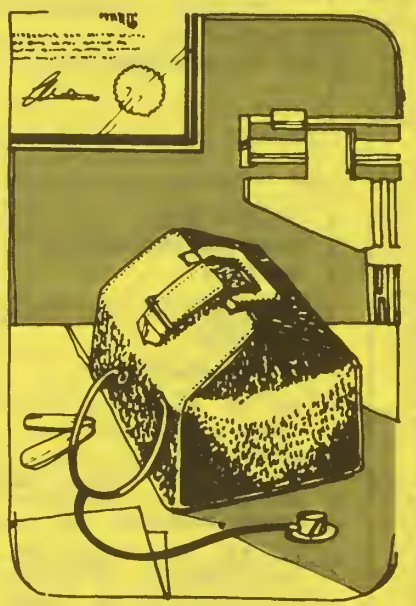
Apr 24: The Management of Aphakia with Contact Lenses, *Perry Rosenthal, MD*, 33 Pond Ave, Brookline, Mass.

May 11: Drug induced Ocular Side Effects, *Frederick Fraunfelder, MD*, Professor and Chairman, Dept of Ophthalmology, University of Arkansas, Little Rock, Ark

Info: Contact John L Sella, MD, 6114 West Capitol Dr, Milwaukee, Wis 53216

To all my patients,

Partners in Good Health

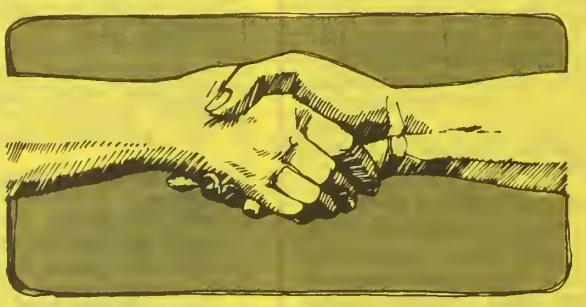


The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

The Communications Department
State Medical Society of Wisconsin
P.O. Box 1109
Madison, WI 53701



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Schedule of Upcoming Programs

December 25-January 7, 1979

Diagnosing Jaundice: Applications of Technological Progress, with Fenton Schaffner, MD, George Baehr Professor, Medicine Chief, Division of Liver Diseases, Mt Sinai School of Medicine, New York City.

Transient Ischemic Attack: Etiology and Diagnosis, with Mark L Dyken, MD, Professor and Chairman, Department of Neurology, Indiana University School of Medicine, Indianapolis.

Elective Induction of Labor: Is It Justifiable?, with Theodore M King, MD, PhD, Director, Former Chairman, FDA, Advisory Committee on Obstetrics and Gynecology, Dept of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine and Hospital.

January 8-January 21, 1979

Transient Ischemic Attack: Early Management Methods, with Mark L Dyken, MD, Professor and Chairman, Dept of Neurology Indiana University School of Medicine, Indianapolis.

Prophylaxis for Viral Hepatitis, with Richard H Parker, MD, Chief, Section of Infectious Diseases, Hospital Epidemiologist, Associate Professor of Medicine, Howard University School of Medicine, Veterans Administration Medical Center, Washington, DC.

* * *

An educational television service of NCME, serving some 100,000 physicians at more than 700 hospitals and medical centers throughout the country, including about 20 hospitals in Wisconsin.

Supported by Roche Laboratories, NCME provides programs in three-quarter-inch U-Matic videocassettes and half-inch Betamax formats.

American Society of Internal Medicine Future meetings:

April 26-29, 1979	Annual Meeting	New Orleans, Louisiana
Sept 28-29, 1979	Interim Meeting	Las Vegas, Nevada
May 15-18, 1980	Annual Meeting	Washington, DC
Sept 26-27, 1980	Interim Meeting	San Diego, California
April 30—May 3, 1981	Annual Meeting	Denver, Colorado

NATIONAL MEDICAL SPECIALTY SOCIETIES

1979 Meeting Dates/Sites

Jan 27-31: American College of Allergists, San Francisco. Info: F P White, 2141 14th St, Boulder, CO 80302.

Mar 22-29: American Society of Clinical Pathologists and College of American Pathologists, New Orleans. Info: J L Normoyle, 2100 W Harrison St, Chicago, Ill 60612.

Apr 2-5: American College of Surgeons, (Spring Meeting), Denver. Info: E Gerrish, MD, 55 E Erie St, Chicago, IL 60611.

Apr 26-29: Annual Meeting, American Society of Internal Medicine, New Orleans, La.

Sept 28-29: Interim Meeting, American Society of Internal Medicine, Las Vegas, Nev.

CONTRIBUTIONS—CES FOUNDATION
October 1978

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1978.

Restricted

Membership Dues—*Aesculapian Society*

Memorials

Mrs Marion P Crownhart—*James E Miller, MD; Myrle Sturlaugson (Crownhart Memorial Fund)*
Dr-Mrs Robert T. Schmidt—*Miss Olga Roessler (Brown County Loan Fund)*
Dr-Mrs Robert T Schmidt—*Mr Charles Woody; Mrs Nathan Zucker*
The Richard Edwards Family—*Dr-Mrs Richard Housner*
Robert B Murphy—*Myrle Sturlaugson*
Dane County Medical Society—*James E Miller, MD*
State Medical Society—*Victor J Wong, MD; Roland S Cron, MD; James W Boren, Jr, MD; James E Miller, MD; Anthony Verdone, MD; Howard Albright, MD; Richard J Muenzner, MD; Richard E Housner, MD; Louis H Geldner, MD; Myrle Sturlaugson* ■

News You Can Use

FEBRUARY IS 'FINANCIAL CHECKUP' TIME

"Annual Financial Checkup for Wisconsin Physicians" is the title of a special seminar for physicians cosponsored by the First Wisconsin Banks and Educational and Advisory Services Corporation, in conjunction with the State Medical Society of Wisconsin. The seminar, to be held at Telemark Lodge, Cable, Wisconsin on Feb 1 and 2, 1979, will concentrate on estate planning, trusts, and financial management. A few of the topics will include: "Defining Your Current Financial Condition," "Your Potential Estate Tax Cost—Recent Tax Law Changes," and "Your Investment and Retirement Programs." Classroom sessions will be held each morning with afternoons open for recreation at the Telemark Lodge facilities. For additional information contact Peter Wood at SMS Madison offices, 257-6781 or toll-free at 1-800-362-9080.

HOSPITAL EMERGENCY SERVICES—REFUSAL OR DELAY

Assembly Bill 624, which became law effective July 1, 1978, provides that no hospital may refuse emergency treatment to a person because the person is or may be unable to pay nor may a hospital delay treatment in order to investigate a person's financial situation if the delay may cause increased medical complications, permanent disability or death. A hospital may be fined $1,000 for each violation. A hospital is not required to provide emergency services beyond its capabilities, but must create a plan for referral of emergency patients when it is unable to provide treatment. (Ch 361, Laws of 1978)

MEDICAL STAFF LAW SEMINAR IN ARIZONA

Can medical staff procedures be effectively handled in-house to avoid litigation and staff problems? There's no 100% solution. But well-informed administrators and attorneys know the pitfalls, the problems, and are aware of the options. A two and a half day seminar, Feb 12-14, 1979, in Scottsdale, Ariz, uncovers the problem areas in bylaws and regulations, explains the effect of new federal and state court decisions, and focuses on the key issues from both practical and theoretical viewpoints. Conducted by Nathan Hershey, LLB and Dennis J Purtell, LLB, the seminar's instructors present meaningful insight into the problems of hospital law and the interrelationship between the governing board and staff. They analyze how to minimize procedural errors, a basic cause of litigation, and help participants to develop effective techniques for anticipating and handling claims and for dealing with the peer review process. Tuition is $335. To register write: Aspen Systems Corp, 20010 Century Blvd, Germantown, Md 20767; or call 301/428-0700.

NEW QUARTERS FOR MCW MED SCHOOL DEDICATED

The Medical College of Wisconsin (MCW) opened the doors of its new quarters at 8701 Watertown Plank Road at a dedication ceremony there November 10. Formerly located on the Marquette University campus, the new building is designed "to aid the academic stress of early medical school years," according to MCW Dean Edward J Lennon, MD. In addition to its teaching, research, and patient care programs, the college provides for MD specialty training, continuing education for physicians, and allied health training. Final cost for the building is expected to be approximately $39 million, down from the originally estimated $42 million. At present there are 600 students in the four-year medical program and 100 students pursuing their master's and doctoral degrees in the basic sciences graduate program. ■

Some serendipitous results of the practice of investigative internal medicine

Burton A Waisbren, MD
Milwaukee, Wisconsin

A PROPOSED approach to the practice of medicine is based on the premise that if a physician approaches some of his patients who suffer from problem diseases with a fierce determination to find a way to help them, he may along the way find out some things of interest.

The story starts in 1801, when Jenner[1] first described the phenomenon of what we now call the delayed hypersensitivity reaction, but which he called "the disposition to sudden cuticular inflammation." Koch[2] brought Jenner's discovery to renewed attention in 1891 and added to it the dimension that the reaction was beneficial to the host. He did this by demonstrating that a guinea pig that exhibited a positive tuberculin reaction had increased resistance to tuberculosis—the so-called Koch phenomenon. Rich,[3] the renowned pathologist of Johns Hopkins, persistently studied the Koch phenomenon and, mostly by deductive reasoning, established the concept that a positive tuberculin test was a sign of an increased ability to resist tuberculosis. Lawrence[4] in 1956 demonstrated that delayed hypersensitivity could be mediated through a discrete substance when he showed that a lyophilized dialysate of lymphocytes from a tuberculin positive guinea pig, when injected into a guinea pig that had not been exposed to tuberculosis, would cause that guinea pig to become tuberculin positive. He called the substance that accomplished this, "transfer factor." Transfer factor has not been defined chemically, but it has a relatively small molecular weight and probably contains adenine, quanine, and hypoxanthine.[5,6]

That the findings of Jenner and Koch might be used to the benefit of the host in a specific manner were demonstrated early when cow pox vaccination was found to prevent small pox, and when BCG vaccine was found to prevent tuberculosis.[1,7] Jenner's original observation, that resistance to one disease might confer resistance to another, was dramatically brought into the modern era of medicine when Davignon et al[8] showed that BCG would protect against acute leukemia, and Morton et al[9] showed that it was helpful in malignant melanoma. From here it did not take large stretches of imagination to try transfer factor against a wide variety of diseases, and, to date, it has been used with encouraging, if not spectacular, results in Wiskott-Aldrich syndrome, sarcoma, nasopharyngeal carcinoma, sarcoidosis, generalized herpes, subacute sclerosing panencephalitis, tuberculosis, leprosy, coccidioidomycosis, metastatic carcinoma, and a wide variety of other similar conditions.[10,11,12,13,14]

Thus, at the present time the investigative practitioner must ask himself each time he sees a patient with a progressive disease not amenable to usual treatment, will transfer factor help?

"A proposed approach to the practice of medicine is based on the premise that if a physician approaches some of his patients who suffer from problem diseases with a fierce determination to find a way to help them, he may along the way find out some things of interest. The story starts in 1801 . . ."

An entirely different subject is that of the slow-growing viruses. It is difficult to understand why the concept of slow-growing viruses took so long to surface, when one considers that the first virus to be described, the tobacco mosaic virus (discovered in 1880 by Iwanonski), is a chronic, slowly growing, virus disease of tobacco leaves. Furthermore, it was known in the 1930s that Parkinsonism followed by

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Presented at the Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, April 16, 1977.
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many years the clinical onset of von Economo's encephalitis, even though to this day we hear little about the very real possibility that Parkinson's disease may be caused by influenza virus still residing within brain cells.

Dr D Carleton Gajdusek[15] is the father of the modern concept of "slow-growing virus diseases," and he came upon this concept in a roundabout way. While in New Guinea on another mission for the United States Public Health Service, he heard of a disease called the "laughing death," that was slowly destroying a remote tribe of natives in the interior. He went to the area and relentlessly pursued the disease for several years, making little progress towards the understanding of its cause. Dr William Hadlon[16] read his publication regarding the pathologic findings in the brains of victims of the disease and wrote a letter inquiring if the disease could be caused by a slow-growing virus of the type that caused a fatal disease in sheep. As I have heard Doctor Gajdusek tell it, at that time he had never heard of scrapies and had not thought of slow-growing virus, but he took the first plane he could get to visit Doctor Hadlon. He learned from him that scrapies is a disease of sheep caused by a durable, slow-growing virus that cannot be destroyed by freezing or boiling. It has a two-year incubation period before it kills the sheep with a neurological disease that first manifests itself when the sheep scrape their backs against the bars of their corrals. With this lead, the brains of the kuru victims were found to contain a slow-growing virus that caused a disease in baboons. This virus along with the scrapies virus were then transmitted to mice, where they undergo intense study to this day. Gibbs and Gajdusek extended the concept of human slow-growing viruses when they showed that the disease subacute sclerosing panencephalitis was caused by the measles virus acting in a slow-growing mode.[17] The final proof of this was obtained in a tragic way when the recipient of a corneal transplant came down with subacute sclerosing panencephalitis two years after receiving a transplant from a patient who had the disease.

Thus, the investigative practitioner, faced with a disease that is progressing and which is unexplained, has reason to pause and consider—could this disease be caused by a slow-growing virus?

With a shift of conceptual gears a specific disease will be considered. This is multiple sclerosis, and evidence that it is, indeed, caused by a slow-growing virus—namely, the measles virus.

"Lawrence in 1956 demonstrated that delayed hypersensitivity could be mediated through a discrete substance . . . he called the substance . . . 'transfer factor.' The investigative practitioner must ask himself each time he sees a patient with a progressive disease not amenable to usual treatment, will transfer factor help?"

To Adams and Imagawa[18] goes the credit for the finding, which has been amply confirmed and expanded, that patients with multiple sclerosis have a higher than usual titer of circulating antimeasles antibodies in their serum.[18,19] In addition, Fisher-Williams and Roberts[20] showed that in many cases the high spinal fluid globulin level that many consider the sine qua non of multiple sclerosis consists of gamma globulin antibodies against the measles virus. The possibility of involvement of antibody activity in multiple sclerosis was further buttressed by the finding of Rola-Pleszcznski[21] that patients with multiple sclerosis had blocking antibodies against measles.

The involvement of cellular immunity in multiple sclerosis has been suggested by several lines of investigators. First, Levy and coworkers[22] found that lymphocytes from patients with multiple sclerosis rosetted against epithelial cells that were infected with the measles virus. Second, Nato and his coworkers[23] showed an association of certain human lymphocyte antigens with multiple sclerosis, and Terasoki et al[24] and others have extended this observation to association of the newly described D locus antigens patterns with multiple sclerosis.[25,26,27] Not only are the lymphocytes of patients with multiple sclerosis unique transplantation antigen-wise, but also they lack normal function as shown by studies of Field et al[28] and Zabriskie et al.[29]

To the serologic and cellular evidence that multiple sclerosis is caused by measles can be added epidemiological studies of Koch et al[30] and Poskanzer[31] who both showed that "epidemics" of multiple sclerosis followed by many years epidemics of measles. Morphological evidence that also tends to confirm this hypothesis is the recent demonstration by Cook[32] of particles that fluoresced with measles antiserum in the small bowel of patients with multiple sclerosis.

If we assume that the serologic, cellular, epidemiologic, and morphologic evidence that has been cited does establish multiple sclerosis as a form of measles, why should we assume it is a disease acting in the slowly growing virus mode? Here the subsequently confirmed work of Carp and co-workers[33] is suggestive indeed.[34] They took extracts of brains from patients who died of multiple sclerosis and injected them into mice. They found that the animals' white blood cell counts became depressed. Serial passage of extracts of brains from the original recipient mice revealed the presence of a white cell depressant factor that acts in mice in a manner similar to that of scrapie and kuru virus. These studies make reasonable the assumption that multiple sclerosis is a slow growing virus disease caused by measles acting in the mode of scrapies and kuru.

How might this relate to the investigative practitioner who is sitting across his desk from a patient with progressive multiple sclerosis? The physician knows that delayed hypersensitivity enhancement is often beneficial to patients with a

wide variety of diseases. He knows that transfer factor is a safe, reliable way to transfer this modality. He suspects that the patient is suffering from an intracellular measles infestation that is acting in the slow-growing virus mode. He is aware of the fact that the patient's lymphocytes are somewhat unique and that they do not function normally. In this frame of reference, does it not seem reasonable for the investigative practitioner to make a covenant with the patient as follows: "I will treat you with transfer factor obtained from the lymphocytes of people immunized against the measles virus, with a mixed bacterial vaccine to stimulate your B-cells, and with BCG to further stimulate your delaved hypersensitivity, to see whether this reasonable approach to therapy will benefit you. You are to continue on all other medications that anyone else thinks may help you, and at all times we will explain everything that is being done and why. For your part, you agree never to sue me for anything, and to cooperate in being available for tests that will be done to try to obtain objective evidence of your immune reactions to the onslaught of immunologic manipulations to which you will be subjected."

"The investigative practitioner, faced with a disease that is progressing and which is unexplained, has reason to pause and consider—could this disease be caused by a slow-growing virus? . . . a specific disease . . . multiple sclerosis . . . evidence that it is, indeed, caused by a slow-growing virus—namely, the measles virus."

At any rate, this is the covenant I made with a patient, co-worker, and dear friend in the summer of 1974. Little did I know then, that he would have 15 other friends who had multiple sclerosis and who were interested in the same covenant. Thus a project in the investigative practice of medicine began, with a gradually increasing number of patients—who were treated with measles specific transfer factor, BCG, and a mixed bacterial vaccine. One of the many challenges posed was how to gain useful information within the confines of the covenant that specifically forbade using the patients as experimental subjects and forbade the withholding of any potentially helpful modality. The intense study of the patients' lymphocytes seemed to offer a reasonable line of investigation, and it was in line with our other research interests. Through a serendipitous route not to be detailed here, it was decided to study the lymphocytes of the patients with multiple sclerosis by elemental dispersive x-ray analysis (EDXA)*.[35] In the EDXA technique, x-rays are beamed at individual cells that are selected for uniform size and non-contamination under the electron microscope. Each element within the cell reflects the x-ray beam in a manner that gives a characteristic curve, the area under which is proportional to the amount of that particular element present within that cell. Thus, the relative amounts of 16 elements as compared to the amount of sulphur in the cell are calculated. All elements can be determined, but the usual elements screened are sodium, magnesium, phosphorus, chlorine, potassium, calcium, chromium, manganese, iron, copper, zinc, nickel, silicon, aluminum, titanium, and cobalt. The relative amounts of these elements in cells from normal individuals are remarkably constant. However, to our delight and surprise, the lymphocytes from 14 of our patients with multiple sclerosis had a distinctive change in electrolyte pattern in that they had significantly elevated amounts of sodium, chlorine, and magnesium, and distinctly decreased amounts of silicon (p values less than .01). No case of proven multiple sclerosis had a normal amount of silicon within their lymphocytes. At this point this is where our journey into the investigative practice of medicine has led us.

"There will be some among you who will be . . . asking yourselves, 'Is he really commenting about how we should be approaching patients with cancer, using multiple sclerosis as a subtle example?' And, of course, the answer is 'yes.' "

*The EDXA studies were done under the direction of Dr Kenneth Seigesmund, Professor of Anatomy, Medical College of Wisconsin, Milwaukee.

What have we been leading up to, and what does all this mean?

First, it must be of some importance that patients with a disease of unknown etiology—multiple sclerosis—have a distinctive elemental pattern within their lymphocytes—low silicon, high sodium, chlorine, and magnesium. In addition, it is reasonable to suppose that the application of EDXA to a wide variety of diseases will reveal a wide variety of new information regarding relationships of the elemental constitution of the cells with their function.

Second, and perhaps equally important, this all has demonstrated that the practice of investigative medicine can lead to findings of importance and interest—findings that probably would not be arrived at in any other manner.

Finally, there will be some among you who will be, at this point, asking yourselves, "Is he really commenting about how we should be approaching patients with cancer, using multiple sclerosis as a subtle example?" And, of course, the answer is "yes."

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continued next page

Practice outcome of residents in Internal Medicine: University of Wisconsin – A report to the State

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EDUCATIONAL accountability falls to those individuals responsible for administrating and providing funds for training specialists in internal medicine. The desired end result of such a training program is to have adequate numbers of well trained specialists in internal medicine providing health care of the citizens of the state and elsewhere. Thus, it is most appropriate to ask of such a training program: "What is your product? Where have they gone and what are they doing?"

In order to answer some of these questions, the Department of Internal Medicine at the University of Wisconsin Medical School surveyed its former residents. It was hoped that after years in practice they would provide valuable information about their careers and further information that might favorably influence the Residency Training Program in the future. The survey was conducted in 1975 and this is a report of the career outcomes and practice settings of these former residents.

The questionnaire was designed to serve two purposes. The first to obtain information about the current career status and practice setting of former residents. The second sought educational feedback that might stimulate review and strengthening of the residency program, the subject of another report. Not every question was answered by every physician, and thus the number of answers varied from question to question. The questionnaire was field tested by faculty and by four former residents in private practice and then put into final form.

RESULTS

Population and sample

Three hundred and two (302) questionnaires were mailed of which 213 (70%) were completed and returned. The earliest year in which training was completed was 1935 (one resident) and the latest year was 1975 (five residents). There were no respondents from residents

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completing training in the years 1936, 1937, 1944, 1945, and 1957. Fifty-one percent (108) of residents completed three or more years and 49% less than three years of training at this university.

Specialty certification

Seventy-five percent (150 MDs) of the 200 internists who indicated their board status were certified by the American Board of Internal Medicine, and the remaining 25% considered themselves eligible for certification.

One hundred and ninety-five (195) respondents stated their subspecialty status. Twenty-six percent (26%) of this group (51 MDs) were certified in a medical subspecialty while 37% considered themselves eligible for certification in a subspecialty. Thus, 63% (123 MDs) considered themselves qualified in a subspecialty.

Faculty appointments

Sixty-seven percent (138) of the 206 respondents to this question had some type of faculty appointment. Of those with faculty appointments 40% (55) had full-time appointments and 60% had less than full-time appointments.

Location and type of practice

Ninety-four (44%) former residents were practicing in Wisconsin. Another 12% were practicing in the neighboring states of Minnesota, Iowa, Illinois, and Michigan. Of the 201 respondents answering this question, 70% were practicing in communities of greater than 100,000 population and 9.5% were practicing in communities of less than 20,000 population. Twenty and a half percent (20.5%) were located in communities of 20,000-100,000 population.

Eighteen percent (18%) of 207 former residents were in solo practice and 40% were in some form of either single or mixed specialty group practice. Forty-two percent (42%) were working in some other type of institution such as a university hospital, the Veterans Administration, the military, and the like.

Of those 83 physicians in group practice, 34% were in groups of 1-5 MDs, 18% in groups of 6-20 MDs, and 48% in groups of 20 to greater than 50 MDs.

Time in patient care

Forty-two percent (42%) of 207 former residents considered themselves spending at least 90% and 19% believed themselves spending at least 80% of their time in patient care. Five percent (5%) of respondents thought they were spending less than 20% of their time with patients. All told, 80% were spending at least 50% of their time in patient care.

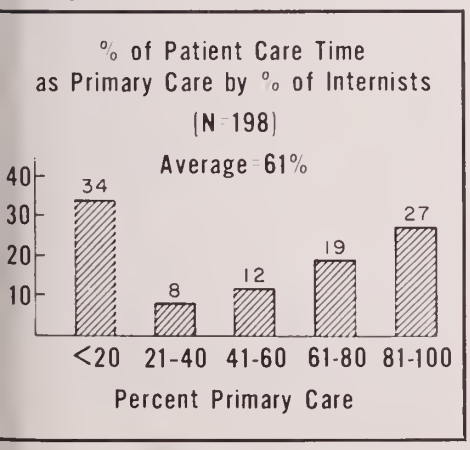
Time in primary care

Figure 1 reveals that 198 former residents answered the following question: "Of the time devoted to patient care, how much is primary care?" The questionnaire defined primary care as first contact and responsibility for care of patients and for the continuity and integration of patient care. Using this definition, 34% of these internists believed that less than 20% of their patient care time was primary care; 27% believed that greater than 80% was primary care. The average of the responses to this question was determined; this showed that the group as a whole thought 61% of their patient care time was primary care.

Time in ambulatory care

Twenty-eight percent (28%) of former residents spend less than 40% of their patient care time and 72% spend greater than 40% as ambulatory patient care. As an average, this group of internists perceived themselves spending 61% of their patient care time with ambulatory patients.

Figure 1



DISCUSSION

Forty-four percent (44%) of former residents are practicing in Wisconsin. By coincidence (and we have no other explanation) this compared closely to the 42% of graduates from the medical school who remain in the state. It is also important to recognize that 12% of Wisconsin trained internists are practicing in neighboring states. Each one of these states has a commitment to training internists, and it is reasonable to assume that some of these practice in Wisconsin. Thus, there is very likely a reciprocal exchange of some talent from one state to its neighbor which provides mutual benefits.

"Respondents to our survey showed that the major commitment of their professional time was to patient care. Of special interest, however, was the large segment (61%) of patient care time that was perceived to be primary care and is supportive of the findings of other studies."

The quality of the product as reflected in specialty certification shows that 25% of former residents were not board certified. This compared to 33% of 9,386 practicing internists who were surveyed by and are members of the American Society of Internal Medicine (ASIM).[1] Our survey did not determine how many internists trained at this University took the certifying examination and either passed or failed it. Seventy-five percent (75%) were certified and all considered themselves eligible for board certification.

It is noteworthy that 22% of former Wisconsin residents were certified in a subspecialty and surprising that 63% considered themselves qualified in a subspecialty.

The ASIM survey[1] showed nearly two thirds of its members reported a secondary specialty. This no doubt reflects the strong trend to subspecialization for whatever reason within the past 20 years.

That specialists in internal medicine significantly contribute to the teaching of health professionals has been documented in other studies. The Mayo Clinic survey[2] showed 45% of its former residents in internal medicine were active on faculties of medical schools. The ASIM[1] found 49.8% of its members, who had a secondary activity, to be teaching in a medical school. The 60 some percent of respondents with faculty appointments in our study bespeaks a continuing commitment to education by former residents of the University of Wisconsin.

The large majority of specialists in internal medicine practice in larger communities. This is born out by both the results of this survey and that of the ASIM[3] in which 79% and 75% respectively of internists were practicing in communities of 50,000 or greater population. Internists are taught to use and depend on highly technical investigative procedures which are necessary for making complex and difficult diagnoses. In addition, internists work with other healthcare professionals in a setting where it is necessary to have hospitals equipped with coronary care units, complex investigative facilities, and the like. Hospitals so equipped are not likely to be located in isolated and lightly populated areas. Thus, it is predictable that graduates from internal medicine training programs would select practice locations in those communities where these resources are more readily available.

It is important to emphasize, however, that historically internists, although located in larger communities, have provided service to patients in a much wider area. It was and still is common for internists to attract patients from within a radius of 50 or more miles. Now a new development is being added to this description. Medical clinics within Wisconsin communities such as Marshfield, LaCrosse, Monroe, Appleton, and others send internists to or supervise other health professionals in smaller communities to provide them medical care. This trend may grow. In the future, internists may increasingly join with family physicians and other health professionals, such as physician's assistants, to form group practices with satellite offices providing primary and comprehensive care within smaller communities.

"Attempts to relate the residency training program at the University of Wisconsin more closely to what practicing internists do has resulted in a significant addition to the curriculum . . . Residents may now receive extended training in ambulatory and primary care."

The apparent attraction of these former residents to various forms of group practice is strongly suggested because only 18% of them were in solo practice. This is in contrast to the 48% in solo practice obtained in the nationwide survey of internists by the ASIM in 1973.[3] No simple explanation for this difference is readily apparent, except to note the historic commitment to group practice that exists perhaps uniquely in Wisconsin and the Midwest. It may be the residents were influenced by a long tradition of well established and effective group practice associations in Wisconsin. In addition, many of these group practices have achieved recognition for the quality of the care they provide which extends beyond the state's borders. It is natural that many specialists in internal medicine will be attracted to this kind of work setting.

More recently, several of these group practices have increasingly been active in the training of residents and medical students from the University of Wisconsin. The residents spend part of their assigned rotations working with physicians within those group practices and assist in the training of medical students there also.

As would be expected, respondents to our survey showed that the major commitment of their professional time was to patient care. Of special interest, however, was the large segment (61%) of patient care time that was perceived to be primary care and is supportive of the findings of other studies. The Mayo survey[2] showed that 73% of former residents in internal medicine spend greater than 50% of their time in delivery of primary care. A survey of internists practicing in the Rochester, New York[4] region revealed that 84% of practice time was "service as personal physician." The survey of the ASIM[5] showed 74% of internists' services to be "continuing care, general internal medicine," and Ebert's[6] survey showed that 85% of internists in the Minneapolis-St. Paul area considered themselves primary care physicians.

The percentage of patient care time perceived to be ambulatory care by these former residents was 61%, the same as for primary care. Ambulatory care is obviously a large part of primary care, but beyond that this common percentage seems a coincidence. That the majority of patient contacts for internists is in the office is born out by other studies. A national study by the National Disease and Therapeutic Index[7] reported in 1971 that for internists 70% of patient contacts are in the office. For eleven Wisconsin internists whose practices were studied in detail by the technique of Individual Physician Profile,[8,9] 59% of patient contacts were in the office.

We believe the evidence obtained from our survey and the results of other studies are in close agreement and are testimonials to the large amount of primary care provided by specialists in internal medicine in this country. In this respect they support Engstrom[10] who, recognizing this in 1967, advocated a closer relationship between the training and actual practice of internists; *ie,* primary and general medical care.

This closer relationship as it pertains to the delivery of primary care has been alluded to in four national studies. These have been called the "big four" or the Millis,[11] Willard,[12] Ravdin,[13] and Witten[14] reports. In a more recent consideration Petersdorf[15] highlighted the controversy between internal medicine and family practice in the provision and training for primary care and concluded, "we should muck out our own stables instead of always attempting to clean the other fellow's first."

Attempts to relate the residency training program at the University of Wisconsin more closely to what practicing internists do has resulted in a significant addition to the curriculum. Within the past two years the Department of Medicine has developed an Adult Medicine Outpatient Clinic at the University Hospital to the point where residents may now receive extended training in ambulatory and primary care.

Finally, there has been a dramatic increase in the number of applicants to the residency program for internal medicine at this University. In 1962 there were 34 applicants for 12 training positions. In 1976, 650 medical school graduates applied for the 22 available positions. Thus, in the past 15 years the number of applicants from neighboring states and the world has increased thirty fold while the number of residency positions doubled. To meet this increasing demand the number of available positions for the first year of training was increased to 25 in 1977, bringing the eventual total number of residents in a three-year program to 75.

A further increase in available positions, when training resources can accommodate them, might attract even more internists to the state. The prospects for this increase become more promising as the university expands its use of existing clinical facilities throughout the state for educational training programs at all levels of patient care.

SUMMARY AND CONCLUSION

A survey of 213 internists who had received part or all of their training in residency at the University of Wisconsin Medical School revealed the following:

(1) 51% completed three or more years of training at this university.

(2) 75% are certified by the American Board of Internal Medicine.

(3) 26% are also certified in a medical subspecialty and 63% considered themselves qualified in a medical subspecialty.

(4) 67% have some type of teaching appointment and of these 40% are fulltime appointments.

(5) 44% of these former residents are practicing in Wisconsin.

(6) 70% are practicing in communities of 100,000 or greater population; only 9.5% are practicing in communities of less than 20,000.

(7) 18% are in solo practice and 40% are in group practice.

(8) Of those in group practice 48% are in groups of 20 or more MDs.

(9) 80% are spending at least 50% of their professional time in patient care.

(10) 61% of their patient care time is perceived to be primary care and 61% to be ambulatory care.

Although limited in scope, this survey provided better answers to commonly asked questions about the practice outcome of former residents.

Because internists provide a large part of the primary and ambulatory patient care in this country, the training program for internal medicine at this university now provides increasing opportunity for training in these areas. ■

EDITOR'S NOTE: The reference list is available upon request to the authors. See footnote at beginning of article.

ABSTRACT/ WISCONSIN AUTHORS

Neoplasms of the large bowel following ureterosigmoidostomy

GAMINI S SOORIYAARACHCHI, MB, MRCP, DCH; ROBERT O JOHNSON, MD; and PAUL P CARBONE, MD, Madison, Wis: *Arch Surg* 112:1174-1177 (Oct) 1977

A poorly differentiated adenocarcinoma of the rectum developed in a 43-year-old man 37 years after ureterosigmoidostomy for epispadias with urinary incontinence. A mass could be palpated in the rectum. An intravenous pyelogram showed a slight dilation of the collecting system in the right kidney and rather low implantation of the ureters into the sigmoid colon. The chest roentgenogram, liver scan, and bone scan failed to show evidence of metastases. An abdominoperineal resection and colon-loop urinary diversion were performed, and the distal end of the sigmoid colon brought out as a colostomy. The adenocarcinoma extended through the bowel wall into the perirectal fat. Two lymph nodes under the tumor showed the presence of malignant cells. Postoperatively the patient was started on a regimen of adjuvant chemotherapy with fluorouracil. He was doing well when seen nine months after his surgery.

A review of the literature indicates that patients who have undergone ureterosigmoidostomy may have as much as a 500 times greater risk than the general population for the development of large bowel neoplasia. The median time interval between the surgical procedure and the diagnosis of the neoplasm is 21 years, and the median age at diagnosis is 33 years. The majority of the lesions were malignant and occurred at the site of ureteric anastamosis.

Because patients with a ureterosigmoidostomy are a high risk group for large bowel neoplasia, they should be carefully followed for any evidence of alterations in bowel habits, rectal bleeding, pain, or rapid development of upper urinary tract obstruction. Annual or biannual radiological examination of the large bowel with soluble contrast medium and proctosigmoidoscopy may help to detect colonic lesions. Such surveillance should be considered especially after elapse of the minimum latent period of five years. ■

CEREBRAL REVASCULARIZATION

A preliminary report on the Marshfield Clinic-St Joseph's Hospital experience

Marc A Letellier, MD and Phillip M Green, MD Marshfield, Wisconsin

• Successful extra-intracranial revascularization procedures have been reported by several authors. This report is a review of our experience with six cases.* Clinical and angiographic details are presented in three of the patients demonstrating good results in all cases. Palpation of the superficial temporal artery was found to be an accurate prediction of anastomosis patency.

FIVE SUPERFICIAL temporal artery (STA) to middle cerebral artery (a distal cortical branch of the middle cerebral artery, MCA) microvascular anastomosis and one occipital artery to posterior inferior cerebellar artery anastomosis have been performed over a five-month period (September 1976 to February 1977) by one of the authors (M. L.). Previously, experience had been obtained with ten other cases. Postoperative angiography, which was performed on all patients, revealed functional and effective shunting of the external carotid circulation to the intracranial circulation.

Three cases are presented in detail, because they are representative of the type of pathology the authors are attempting to improve.

Case reports

Case 1: A 48-year-old, right-handed, white male was in relatively good health until late August 1976, when he developed drooping of his left face area and slurred speech. The drooping improved in the next few hours, but the slurred speech continued for 24 hours. This symptom complex recurred several times in the next few weeks. The patient was admitted to the hospital, his examination was normal, except for some flattening of the left nasal labial fold. Four-vessel angiography revealed a right middle cerebral artery occlusion (Fig 1). No other lesion was seen. There was relatively poor filling of the distal middle cerebral artery via collateral channels. A right STA-MCA anastomosis was performed successfully. Postoperatively the patient did well and the transient symptom did not recur. Follow-up angiographic studies three months postoperatively revealed patency of the anastomotic site with doubling in radius of the STA and excellent filling of the middle cerebral artery to the level of occlusion. There were no recurrence of symptoms on follow-up eight months later (Fig 2).

Case 2. A 60-year-old, right-handed, white female had a history of four episodes of loss of consciousness. The episodes were preceded by dizziness and lightheadedness. On admission the neurological examination was normal. Four-vessel angiography revealed complete occlusion of the left internal carotid artery at its origin with some collateral circulation through the left ophthalmic artery (Fig 3). There was a 95% stenosis of the right internal carotid at its origin. The left vertebral artery was occluded proximally with re-constitution through collaterals just below the base of the skull. The right vertebral artery had a 75% stenosis at its origin and a 40-50% stenosis at mid-segment. Although the symptoms could be due to vertebrobasilar insufficiency, her significant carotid disease could also be the source of her symptoms.[1] A carotid endarterectomy was performed on the right, followed a week later by a STA-MCA bypass. We were hoping that improving the anterior circulation would increase the infratentorial circulation through the posterior communicating arteries. Angiography was performed three days postoperatively with excellent results (Fig 4). The patient has remained symptom-free since surgery.

Case 3. A 60-year-old, right-handed, white male, with a 35-year history of hypertension, first noticed in March 1976 a cloud over the right eye getting worse over the following week. In July the patient experienced sudden weakness of the left face area and the left upper extremity, with slight slurring of speech, but no other language problem. The weakness improved in 24 hours with residual difficulty in coordination of his left hand. The family observed shortly thereafter, intermittent periods of confusion. The patient was admitted for evaluation. Examination revealed mild decrease in strength of the distal muscles of the left upper extremity. Retinal arterial pressures were markedly decreased on the right side. The right eye values were 40/10 as opposed to 80/50 on the left side. Four-vessel angiography revealed a complete occlusion of the internal carotid above the bifurcation with some moderate collateral circulation via the anterior communicating artery (Fig 5). The patient underwent a right STA-MCA anastomosis which he tolerated very well. Postoperatively the patient's vision improved subjectively and his intermittent confusion disappeared. An angiogram performed three days postoperatively revealed excellent filling of the middle cerebral territory and immediate doubling in size of the superficial temporal artery (Fig 6).

Two more cases, identical in their clinical and pathological findings, were operated with similar success. A sixth case, reported elsewhere,[2] with fibromuscular dysplasia of the vertebral arteries, had an occipital artery to posterior inferior cerebellar artery anastomosis. Good surgical and clinical success was obtained.

Discussion

Yasargil, et al[3,4,5] reported the first successful STA-MCA anastomosis. The procedure was further developed and popularized by Reichman and Chater.[6,7] The authors have used their combined teachings to perform the surgery. Well over 1,000 such procedures have been performed since 1967. Comprehensive analysis of case material and results have been furnished by Schmiedeck, Chater,

*Since submission we have performed nine new cases with similar clinical and technical results.

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Publication support from the Marshfield Clinic and Marshfield Medical Foundation.

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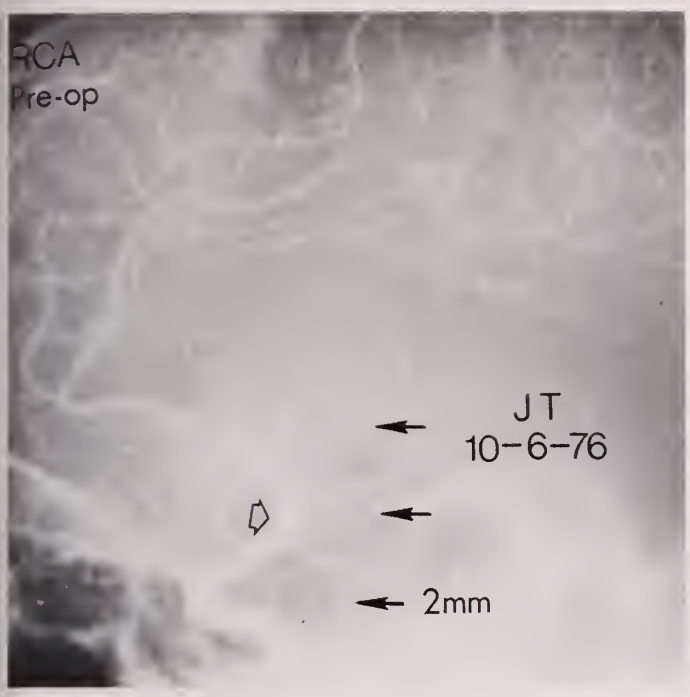

Figure 1—Preoperative RCA, open arrow shows middle cerebral occlusion below the trifurcation, some collateral circulation via the anterior cerebral. Dark arrows showing size and trajectory of superficial temporal artery.

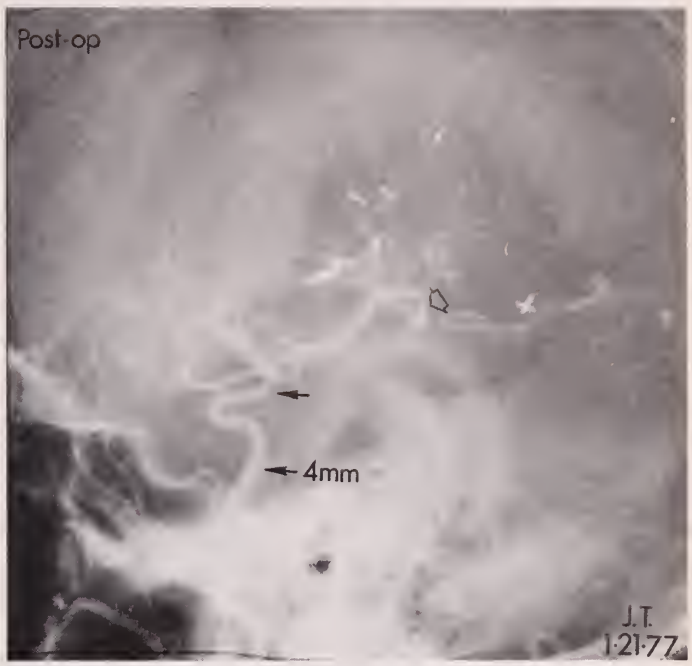

Figure 2—Three months postoperatively. Selective external carotid angiogram. Open arrow—level of anastomosis. Closed arrows—doubling of radius of superficial temporal artery. Excellent filling of all branches of middle cerebral group to the level of occlusion.

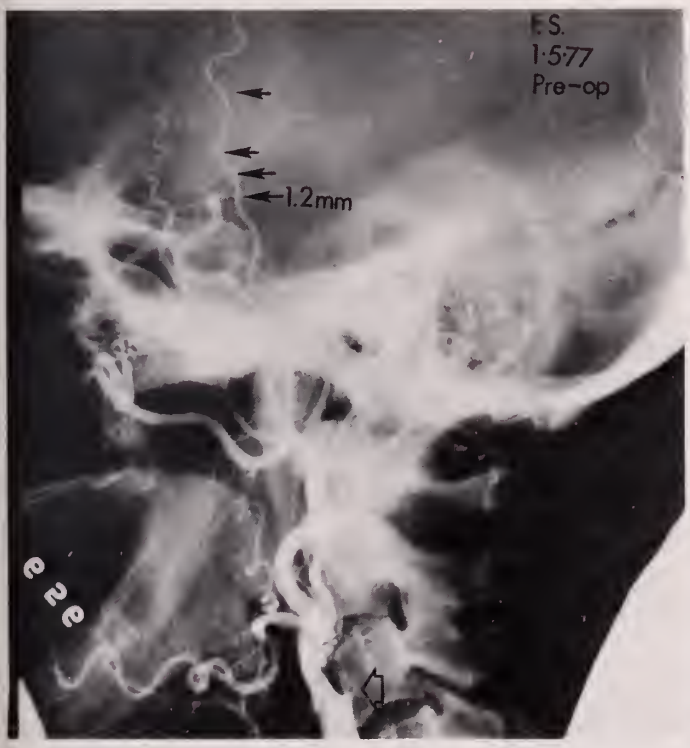

Figure 3—Common carotid injection. Open arrow—occlusion of internal carotid artery. Closed arrow—size and position of superficial temporal artery. Also showing filling of intracavernous portion of carotid artery via ophthalmic artery.

Figure 4—Common carotid injection, one week postoperatively. Closed arrows shows position and size of superficial temporal artery and level of anastomosis.

Figure 5—RCA preoperatively. Small dark arrows indicate the radius and the position of the branch of the superficial temporal artery to be used.

Figure 6—Selective injection of external carotid artery three days postoperatively. There is immediate doubling in size of superficial temporal artery with excellent filling of all branches of the middle cerebral artery.

Reichman, and Sundt more recently.[6,7,8,9] The technical success of the surgery has increased over the years because of better instrumentation, suture materials, and surgical skills. Most authors have reported from 85-95% patency rate.[1,7] In the very small series reported here, the authors have had 100% patency.

The authors and others[1,7,9] have found that angiography is the surest way to prove and evaluate patency. Most authors have preferred to wait three months or more before evaluating a patient by arteriography because spasm of the donor artery would prevent adequate visualization of the anastomosis. It is thought that three months would allow a better estimate of the amount of collateral flow ultimately available to the brain. This procedure was followed with the first two cases. However, in the authors' last four cases, angiography was performed within the first postoperative week and good patency was observed without spasm of the donor vessel. Indeed, in Case 3, there was immediate doubling in size of the radius of the superficial temporal artery with excellent filling of all branches of the middle cerebral artery (Figs 5 and 6). There was 100% correlation between palpation of strong superficial temporal artery pulsation postoperatively and the patency of the graft. A doppler flow probe was not used to evaluate the surgery as others have reported.[1,7] We intend to evaluate future patients with palpation to determine if this method reliably predicts postoperative patency.

Conclusion

The extracranial to intracranial bypass procedure may in certain cases be useful as a new technique in the prevention, but not in the treatment of stroke. Prospective studies are needed to properly formulate the indications and contraindications of this procedure. The authors and others[1,6,9] have shown that it is technically feasible and beneficial in the cases presented in this report.

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The EMT-Paramedic in an emergency system

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EMERGENCY, prehospital advanced life support[1] is popular in the United States as evidenced by the development of 215 identifiable emergency medical technician (EMT)-paramedic programs. Implementation of such programs must be approached with in-depth consideration of need, available resources, and demands of the emergency medical system concept. EMT-paramedics, by themselves, are not a panacea for effective prehospital care. Consideration must be given to implementation of the entire system of which the EMT-paramedic is but a component if care is to be effective. These components include public education, access to the system, rapid response of appropriately trained teams, advanced life support to provide patient stabilization prior to transportation, medical communications, transportation to appropriate medical care, continuing education, close medical supervision, and evaluation of system results.

The Milwaukee area EMT-paramedic system began in November 1973 with the first EMT-paramedic unit in West Allis with a second unit placed into service in April 1974 in Wauwatosa. The experience in these two communities with a combined population of 130,325 and an area of 24.7 square miles in which the EMT-paramedic units, utilizing a selective dual response system, have evaluated and treated approximately 6,000 patients through March 1977, is the basis for our recommendations.

The public must be educated to seek timely entry into the system. These educational programs should include, but not be limited to, the premonitory symptoms of illness, such as the significance of chest pain or the possibility that "indigestion" may not be an "upset" stomach and that generalized weakness may be the result of cardiac arrhythmia, occult hemorrhage, transient cerebral ischemia, hypoglycemia, or hypovolemia. The community should be trained to provide cardiopulmonary resuscitation (CPR) while awaiting the arrival of emergency personnel. Only 34 of 379 patients had the advantage of public CPR. However, 17 of these patients (50%) were successfully resuscitated and 9 (26%) were discharged from the hospital alive.

The public must know whom to call. Most people do not know their emergency number, especially when they are excited or when separate telephone numbers exist for fire, police, and emergency medical services. The nonresident has additional difficulties in gaining access because of geopolitical boundaries. Time delays can be minimized by a publicized, central emergency number.

The system must provide prompt response of adequately trained personnel to assess the patient, begin basic life support procedures, stop hemorrhage, and prevent further harm. A patient who has suffered a respiratory or cardiorespiratory arrest needs basic life support as soon as possible, ideally within three minutes of the time of insult, to have the best chance for recovery and maintenance of function. Adequately trained EMT-basic personnel (85-hour Department of Transportation course) can perform these tasks. The training of EMT-paramedics is an extensive and expensive educational process. The maintenance of the skills and knowledge necessary to continue to provide high quality advanced life support mandates continuing education and critique plus frequent use of the EMT-paramedic core of knowledge and skills.[2] The experience in our system suggests[3] that only 8% of injured patients and 36% of all patients seen in a selective dual-response system require the advanced skills of the EMT-paramedic team. It becomes progressively more difficult to maintain skills and knowledge as the proportion of patients not needing advanced life support increases.

A layered or selective response system provides quick response of EMT-basic personnel whether they are police, fire, ambulance, or rescue squad with a simultaneous dispatch of the EMT-paramedic advanced life-support team. Trained public safety personnel in the dispatch center determine whether the EMT-paramedic team is required from information provided by an "informed" public. A key word list may assist dispatcher decisions. After evaluation, the basic life-support team may cancel the EMT-paramedic response or request their assistance should they not have been initially dispatched.

The benefits of treatment at the scene and en route to the hospital must exceed the risk of the delay associated with an evaluation which includes vital signs, an electrocardiogram, a problem-oriented history,

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and stabilization prior to transport. The treatment modalities should be selected to provide the maximum benefit of life support and yet not further delay definitive hospital care.

Three protocols for the management of the pulseless, nonbreathing patient are used in this system. If the patient is an infant or a child, the difficulty of establishing an intravenous infusion, the narrow limits of weight-adjusted drug administration, and the lack of multiple system senescent disease dictate initiation of basic life support (CPR) and conveyance. If a cardiopulmonary arrest is secondary to trauma or hypovolemia ("empty heart"), prolonged resuscitation will not succeed unless the hemorrhage is stopped; therefore, treatment for these patients may include airway establishment, ventilation and closed chest massage, military antishock trousers, intravenous volume support with lactated Ringers solution, administration of sodium bicarbonate, external hemorrhage control, fracture immobilization, and expeditious conveyance. If the cardiorespiratory arrest in the adult is the result of acquired cardiovascular, respiratory, and/or central nervous system disease and as long as an intravenous infusion is established, conversion to an effective cardiac rhythm is desirable prior to transport since effective cardiopulmonary resuscitation is more difficult to accomplish during transportation.

In this system, resuscitation was attempted in 379 pulseless, nonbreathing patients. Thirty-one percent (118) were successfully resuscitated before arrival at a hospital and 15% (56) were discharged from the hospital alive.

Undue emphasis has been placed by the press and the public on the pulseless, nonbreathing patient since an effective system with advanced life-support capabilities benefits a variety of injured and acutely ill patients. The cardiac arrest patient accounts for 6% of patients in this system, but the ability to prevent a cardiac arrest by suppressing myocardial irritability, to provide adequate oxygenation and ventilation, to replace intravascular volume losses especially during prolonged extrication, to prevent brain damage by administration of intravenous glucose to the hypoglycemic patient, and to reverse narcotic overdose prior to transport accounts for other important but less appreciated benefits of prehospital advanced life support.

The last component of the system is the hospital that provides the paramedic base for standard physician direction to the EMT-paramedic teams. EMT-paramedics are not "junior" doctors. They are well-trained in a narrow area of emergency care but must function under physician direction and supervision. Multiple paramedic bases manned by large numbers of medical personnel will decrease the quality of care. Base physicians must understand the system, have confidence in the EMT-paramedic teams' ability or limitations, be thoroughly familiar with the protocols and standing orders, and be able to function utilizing EMT-paramedic eyes, ears, and hands to render diagnosis and treatment.

To provide an effective advanced life-support system, there must be continuing education and evaluation. Continued training must be provided to maintain knowledge and manipulative skills. Evaluation identifies changes in the results and suggests the direction and scope of continuing education. Evaluation must include tracer conditions to measure effectiveness of advanced life-support teams, maintenance of individual skill records, and continued assessment of knowledge. In this system, the manipulative skill record in pulseless, nonbreathing patients includes successful endotracheal intubation in 97%, 332 of 342 patients, and a peripheral intravenous infusion in 93%, 344 of 370 patients. However, as evidence of improved skills with continued frequent use, peripheral intravenous infusions were successfully established in 97%, 64 of 66 patients in the last six months. If medical evaluation is not accomplished on a regular basis, subtle changes in the system will be undetected and such a system is without appropriate direction and supervision.

Effective, prehospital emergency care is an achievable goal which results in preservation of life and reduction of disability. If the advanced life-support (EMT-paramedic) concept is employed, the entire system must be implemented and strong medical supervision and evaluation provided.

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ABSTRACTS/ WISCONSIN AUTHORS

Paper presented before Wisconsin Neurological Society, October 28-29, 1977, in Green Lake

Botulism—seven cases occurring in three outbreaks

Robert W Graebner, MD, Madison

This is a review of seven cases of Type A botulism cared for by the author. The cases represent a wide spectrum of the disease, but all patients survived. Five patients received guanidine hydrochloride without significant benefit.

Emphasis is placed on the early recognition of this disorder based on the neurological symptoms and findings. Possible cases should be brought to the immediate attention of public health authorities. Newer diagnostic techniques and concepts of treatment are discussed.

Botulism should be considered in the differential diagnoses of patients presenting with an acute paralytic syndrome. Bulbar and ocular involvement is usually quite prominent, and may be confused with the forms of Guillain-Barre syndrome associated with bulbar involvement. ■

Management of premature rupture of membranes

Luis B Curet, MD, Madison, Wisconsin

THE MANAGEMENT of premature rupture of the membranes continues to be a controversial issue. The following article represents an attempt to bring clarity to the issue and provide a rational approach to therapy. The all important assessment of risk of sepsis versus risk of hyaline membrane disease remains the key to management.

IF ONE DEFINES premature rupture of the membranes as rupture no less than one hour prior to the onset of labor, then rupture of the membranes occurs in approximately 12% of all pregnancies and in nearly 20% of all pregnancies terminating in delivery of premature infants.

When the latent period (time between rupture of the membranes and the onset of labor) is unduly prolonged (greater than 18 hours), maternal morbidity and infant mortality and morbidity increase. Prematurity further complicates the situation. In those instances the physician has an option of either to intervene and effect delivery or treat expectantly while awaiting the onset of spontaneous labor.

Most investigators have ascribed the increased perinatal mortality to sepsis. However, a recent report by Badda[1] casts doubt on such an explanation. In a group of infants delivered between 33 and 37 weeks gestation, after premature rupture of the membranes, she found an increase in both sepsis and perinatal mortality as the latent period extended beyond 24 hours. The incidence of hyaline membrane disease, however, remained unchanged.

In a similar group of infants delivered between 28 and 32 weeks gestation, the incidence of sepsis remained stable after 48 hours while the incidence of hyaline membrane disease and perinatal mortality decreased significantly.

Our own observations at the University of Wisconsin Perinatal Center (Table 1) indicate that the major cause of perinatal death before 34 weeks is hyaline membrane disease and not sepsis. Only after 34 weeks, when presumably the majority of babies have pulmonary maturity, does sepsis acquire a primary role in perinatal death.

Based on these observations we have adopted a protocol of management which attempts to identify patients who should be treated expectantly and those who should be actively treated (Fig 1).

Before proceeding with treatment, however, great care must be taken to establish the diagnosis. We consider the most reliable evidence to be amniotic fluid seen coming out of the cervix on sterile vaginal examination. If this is not seen, then a smear of the endocervix can be obtained and fetal cells can be looked for. Fetal squamous cells identified after staining with Quinaldine Blue appears to be very reliable. The use of Nitrazine paper is of value only in a negative way. If the paper does not change color, this indicates that the membranes are *not* ruptured. Should the paper change color, the diagnosis remains equivocal as urine, blood and cervical mucus can cause a change in pH similar to amniotic fluid.

It is important to remember that digital examinations will favor the development of sepsis and are therefore contraindicated until a final decision to deliver the patient is made. Therefore, on admission one sterile vaginal examination with a speculum only is made to establish the diagnosis. Once the diagnosis is established, one proceeds according to the scheme shown in Figure 1. This scheme allows for the vital separation of patients according to gestational age and fetal pulmonary maturity and therefore will distinguish between babies at risk for sepsis and those at risk for

Table 1—Premature rupture bow at < 37 weeks

Weeks	27	27-30	30-32	32-34	34-37
Survivors	1	7	4	24	209
Perinatal deaths	17 (94%)	9 (56%)	5 (56%)	6 (20%)	8 (3.7%)
TOTALS: 290 Babies	18	16	9	30	217

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■ SUPPORTED BY THE WISCONSIN PERINATAL CENTER, SOUTHCENTRAL REGION, MADISON

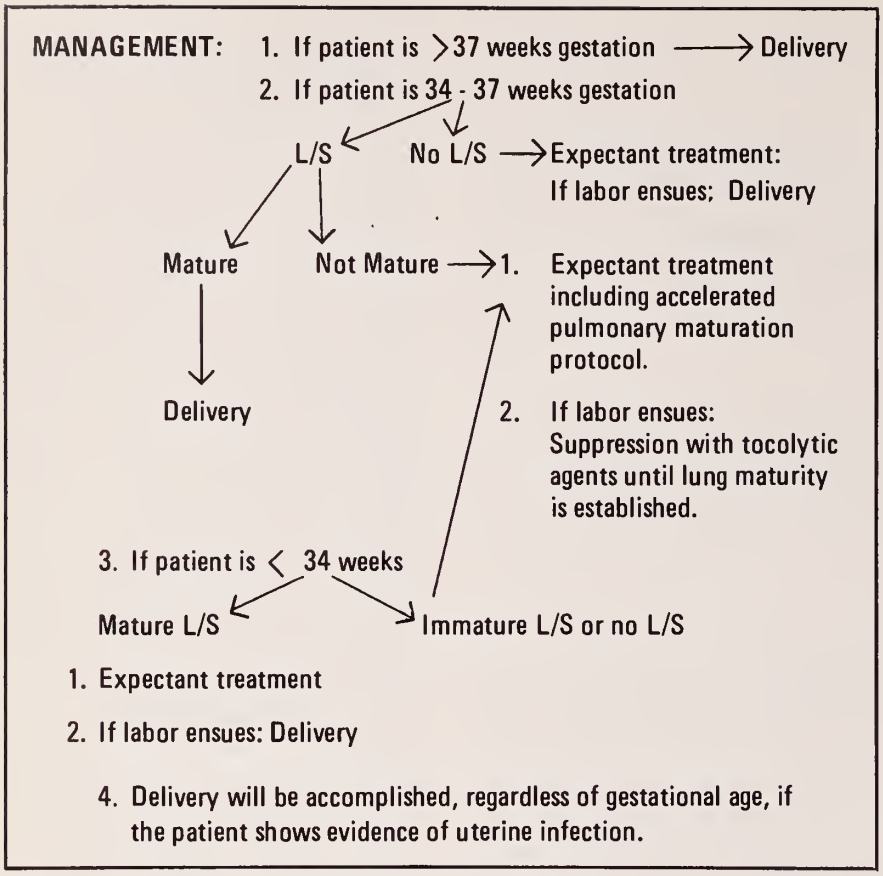

Figure 1—Premature rupture of membrane protocol.

hyaline membrane disease, thus allowing for a rational plan of management. Amniocentesis should be performed under ultrasound as amniotic fluid is usually scanty and thus multiple punctures and fetal injury are avoided. There are instances where amniotic fluid cannot be obtained by amniocentesis, yet a sample could be obtained from the vaginal pool. We are currently studying the co-relation between L/S in amniotic fluid obtained both ways, and a recommendation on the use of L/S in amniotic fluid in the vaginal pool must await further data collection.

The pulmonary maturation protocol refers to the use of adrenal corticosteroids administered to the mother in an effort to accelerate fetal lung maturation. Contrary to the widely held opinion, there is not enough data to warrant the routine use of such agents. The National Institutes of Health is sponsoring a double-blind collaborative study at the universities of Wisconsin, Miami, Tennessee, Manitoba, and Northwestern to determine the efficacy and both short and long-term complications of the use of dexamethasone for such indications. Given the present state of affairs, I believe that corticosteroids should only be given under an experimental protocol.

Lastly, a word about the use of prophylactic antibiotics. There is no data to indicate that the use of antibiotics improves perinatal outcome. As a matter of fact, their prophylactic use might be hazardous in terms of promoting the emergence of resistant strains and also masking infection in the neonate in addition to interfering with the results of microbiological cultures. It appears that the safest course of action is to withhold the use of antibiotic therapy to the mother until clinical evidence of sepsis is present. As under such conditions perinatal mortality soars, it is imperative that patients treated expectantly be carefully monitored for signs of infection.

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ABSTRACTS/ WISCONSIN AUTHORS

Paper presented before Wisconsin Neurological Society, October 28-29, 1977, in Green Lake

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Subacute spongiform encephalopathy: electroencelphalography light microscopy and electron microscopy in two cases

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Two cases of subacute spongiform encephalopathy were evaluated with multiple electroencephalograms. In one case, biphasic and triphasic bioccipital complexes were noted on the initial electroencephalogram. On subsequent electroencephalograms, these complexes became more prominent during the interval when myoclonus developed. Myoclonus in this patient did not correlate with cortical electrical activity. Terminally, the patient did not demonstrate periodic complexes. The second case had biphasic and triphasic delta maximal in the right occipital region initially. During the following four months the EEG changes were characterized by increasing periodicity which was associated with the development of myoclonus. Burst suppression was present in the record during the last month of life.

Both patients had light microscopic and electron microscopic examination of their brains. The most pronounced spongiosis occurred in the regions of the prominent EEG changes. A review of the literature with respect to electroencephalographic variants and pathological changes was present. ■

Renal complications during sulfonamide therapy for systemic nocardiosis

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• Renal complications due to sulfonamide therapy for systemic nocardiosis in two cancer patients are reported. Both patients manifested anuria due to concretions of sulfonamide crystals. Treatment with fluids and alkali resulted in the improvement of renal function. One patient required, in addition, retrograde catheterization with lavage of the ureter and renal pelvis. The pharmacokinetics of sulfonamides, pathophysiology, management and prevention of sulfonamide nephrotoxicity are discussed.

ALTHOUGH SULFONAMIDES have been in clinical use since 1936 and improved pharmacokinetic knowledge has reduced renal complications, nephrotoxicity can still occur. The risk of nephrotoxicity may be higher when large doses are used for prolonged periods to treat opportunistic infections such as nocardiosis. We report here two cancer patients with renal complications resulting from sulfonamide therapy for Nocardia infections. The drug metabolism, renal pathology, and the management of sulfonamide nephrotoxicity are reviewed.

Case reports

Case 1. A 54-year-old woman had a left radical mastectomy in January 1973 for adenocarcinoma, with 11 positive axillary nodes. Despite postoperative radiotherapy, disseminated disease developed in January 1974 and the patient was treated first with 5-fluorouracil and then with "COMP" (cyclophosphamide, vincristine, methotrexate, and prednisone). In November 1975 the patient developed fever, chills and a red, tender subcutaneous left arm nodule which increased in size over the next two weeks.

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She was hospitalized and the physical examination revealed a temperature of 38.9 C (102 F), a swollen, edematous left arm, and atrophy of the left hand muscles. A 5 cm x 5 cm subcutaneous abscess overlying the left biceps muscle was surgically drained, releasing 5 ml of purulent fluid. This fluid showed a heavy growth of *Eikenella corrodens* and "Gram-positive branching rods" which grew Nocardia. The laboratory studies showed a white blood cell of 4,700/cu mm with 91% polymorphonuclear leukocytes and 2% band-forms. Fasting blood sugars ranged from 200-400 mg/100 ml. The urinalysis was normal except for glycosuria. The chest x-ray film showed a left pleural effusion, and cultures of blood, urine, and pleural fluid grew no organisms. The patient received insulin and triple sulfa therapy, 1.5 Gm orally every six hours. The blood sulfonamide level was 5.6 mg/100 ml (therapeutic level 4-12 mg/100 ml) on November 24, 1975 and was 11.8 mg/100 ml five days later. She was discharged although she still had occasional fever and bone pain.

Two weeks later the patient noted crystalluria while testing her urine sugar at home and she discontinued sulfonamide therapy. The next day she developed severe oliguria and was admitted to the hospital on the following day. The physical examination revealed that she was afebrile and normotensive. The abnormal findings included ptosis of the left eyelid, left pleural effusion, hepatomegaly, finger-clubbing and pitting edema of both legs and left arm. The previously noted abscess site was much improved.

The laboratory studies included creatinine 1.8 mg/100 ml, blood urea nitrogen (BUN) 22 mg/100 ml, blood sugar 200 ml/100 ml, blood sulfonamide level 3.9 mg/100 ml, and arterial pH 7.54. The catheterization of the bladder returned 5 ml of dark red urine which contained many red blood cells but no crystals, casts, or organisms. The patient received oral sodium bicarbonate, intravenous fluids, furosemide and albumin, but remained severely oliguric (15 ml of urine per 24 hours). Two days after admission, her plasma creatinine level was 4.8 mg/100 ml, BUN 41 mg/100 ml, and the urine showed hyaline and granular casts.

The cystoscopy showed edema and a yellow paste-like material in the right ureteral orifice. The ureter could not be catheterized, but the retrograde study showed filling defects in the ureter and pelvis (Fig 1), and ureteral lavage reestablished some urine flow. There were similar filling defects on the left side and a No. 6 ureteral catheter was left in place with good drainage. The urine flow increased to 2500 ml/day on the third day, and an intravenous pyelogram performed on the following day showed improvement. After another two days the plasma creatinine level was 1.6 mg/100 ml, BUN 29 mg/100 ml and the urinalysis showed sulfonamide crystals. The patient died on January 2, 1976 from her progressive malignancy.

Case 2. A 58-year-old woman presented with undifferentiated small cell carcinoma of the lung (histologically confirmed) and was treated with local radiotherapy, cyclophosphamide, and dactinomycin. Oral cyclophosphamide was continued for the next three years. She developed *Pneumocystis carinii* pneumonia (biopsy proven) in No-

Figure 1—Composite intravenous pyelogram of patient in Case 1 on December 15, 1975 showing filling defects.

Figure 2—Intravenous pyelogram of patient in Case 2 on January 30, 1975 showing a severe degree of clubbing of the calyces.

vember 1974; and while improving on pentamidine, she developed tender, red, draining nodules on her face and nasal septum. These lesions and one induced sputum specimen grew Nocardia; and sulfadiazine, 9 Gm orally every day, was begun in December 1974.

In January 1975 the patient developed nausea and vomiting and sulfonamide therapy was therefore discontinued. However, the skin lesions increased and sulfadiazine, 8 Gm daily, and minocycline, 100 mg twice daily, were begun on January 20, 1975. Eight days later, the patient developed nausea, vomiting, crystalluria, and hematuria. The blood sulfonamide level on the following day was 25.5 mg/100 ml (therapeutic level 8-12 mg/100 ml) and the intravenous pyelogram showed bilateral hydroureter (Fig 2). The patient was treated by discontinuing sulfonamide therapy and beginning intravenous fluids and furosemide. On January 31, 1975 anuria developed for 24 hours and the plasma creatinine increased to 3.8 mg/100 ml. After three days the urine output returned and the blood sulfonamide level decreased to 14.7 mg/100 ml. On the following day the blood sulfonamide level was 1.1 mg/100 ml. The intravenous pyelogram on February 7, 1975 showed improvement and the patient was discharged a week later with normal renal function. The treatment for nocardiosis was changed to ampicillin, 1 Gm orally four times a day; triple sulfa, 1 Gm orally four times a day; and sodium bicarbonate, 1.3 Gm orally four times a day. Her skin lesions healed by March 14, 1975 and her sulfonamide therapy was discontinued in January 1976. The patient was last seen in July 1976 with no detectable recurrence of either her malignancy or the nocardiosis.

Discussion

"Sulfonamide" is a generic term for para-aminobenzene sulfonamide derivatives, most of which have various side chains attached at the number one amide nitrogen. The sodium salts of these drugs are water soluble, are well absorbed from the small intestine and to a lesser extent from the stomach, and are plasma protein bound (Goodman and Gilman, 1975[1]). The volume of distribution is usually the extracellular space, although some derivatives also enter cells. Some of the properties of commonly used sulfonamides are given in Table 1. "Triple sulfa" preparation consists of sulfamethazine, sulfadiazine, and sulfamerazine and is based on the observation that different sulfonamides can be dissolved to their individual saturation points with additive antibacterial effects but without the risk of increased crystal formation.

The sulfonamides are acetylated in the liver, at the free amine nitrogen, with loss of bacteriostatic activity and generally decreased solubility (Goodman and Gilman, 1975[1]). Rate of acetylation varies with different sulfonamides and in a given patient also depends on the genetically determined acetylator

phenotype (White and Price-Evans, 1968;[2] Schroder and Price-Evans, 1972[3]). Phenotyping a patient as a slow (recessive) or rapid (dominant) acetylator may be helpful in assessing the risk of sulfonamide-toxicity (Schroder and Price-Evans, 1972;[4] Potgieter and Oudtshoorn, 1969[5]). Rapid and simple methods of determining acetylator phenotype have been described (Schroder, 1972[6]).

Effective blood levels of sulfonamides range from 6-15 mg/100 ml although these levels do not exclude the possibility of renal toxicity (McLean, 1944[7]). The serum half lives range from 5-15 hours for short-acting sulfonamides and 35-40 hours for long-acting varieties (American Medical Association, 1971[8]). The main route of excretion is renal, by glomerular filtration and proximal tubular secretion (Probenecid blocked), while part of the drug is reabsorbed from the tubules (Cohen and Pocelinko, 1973;[9] Goodman and Gilman, 1975[1]). The drug can appear in urine 30 minutes after oral administration and small amounts are found in feces, bile, and milk (Schroder and Price-Evans, 1972[3]).

Renal complications due to sulfonamides include drug crystalization in renal tubules, pelves and ureters (reversible without late sequelae), tubular necrosis without crystalization, necrotizing arteritis with fibrinoid changes in vessels and leukocyte infiltration and possibly retroperitoneal inflammation (MacLean, 1944;[7] More *et al*, 1946;[10] Aberhouse and Tankin, 1946;[11] Lehr, 1957;[12] Schainuk and Hano, 1967;[13] Goodman and Gilman, 1975[1]). The toxicity may be enhanced by blood levels above 8 mg/100 ml, urinary stasis or impaired renal function and low urine pH or temperature (Zide, 1944[14]).

Patients may present with renal colic or back pain, painful, frequent or bloody urination, crystalluria (depends on the temperature of the urine at the time of testing), oliguria, albuminuria or acute renal failure.

The treatment depends upon the type and severity of the renal complications, and the therapeutic measures of increasing aggressiveness include:

1. Discontinuing sulfonamide therapy and administration of oral or intravenous fluids, diuretics and sodium bicarbonate (increasing urinary pH above 7.5 generally increases the solubility of the drug 3-10 times) (Jensen and Fox, 1943[15]). In cases with rapidly progressing oliguria, early administration of mannitol may prevent anuria (Winterborn and Mann, 1973[16]).
2. Transrectal or transvaginal distal ureteral massage to remove impacted crystals (Aberhouse and Tankin, 1946[11]).
3. Renal diathermy to increase urine temperature and dissolve crystals has been described in early literature (Aberhouse and Tankin, 1946[11]).
4. Ureteral catheterization and lavage with warm 5% sodium bicarbonate, leaving the catheters in place for 24-48 hours.
5. Dialysis.
6. Nephrostomy.

The two cases reported here demonstrate the variable clinical presentation. Case 1 developed episodic crystalluria and ureteral obstruction after three weeks of standard dosage with a fairly soluble triple sulfa preparation, with high blood levels occurring after one week of therapy. After urinary obstruction developed, the blood levels were not helpful and crystalluria was hard to demonstrate. In case 2, a fairly high dose of a less soluble sulfonamide caused urinary blockage after only one week of therapy, with crystalluria and high blood sulfonamide levels. The renal complications of the first patient were treated successfully by retrograde catheterization and lavage of the ureters. However, conservative measures were successful in the second patient.

Despite decades of experience with sulfonamides, renal complications still occur. It is useful to review the pharmacology and the nephrotoxicity because these drugs remain clinically useful in nocardiosis, chancroid, toxoplasmosis, and in other specific indications. The sulfonamides are given in high dosage and for prolonged periods in such infections and these patients may be at increased risk of developing renal complications. Precautionary measures such as increased fluid intake, the use of more soluble sulfonamides and monitoring of blood sulfonamide levels are useful, and prophylactic use of alkali and the determination of acetylator phenotypes may be considered for selected patients.

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Table 1—Degree of acetylation, solubility and protein-binding of sulfonamides[5,17,18]

		Solubility			
Sulfonamide	% Acetylation	mg/100 ml in water at pH 5.5	mg/100 ml in serum at 37°C	mg/100 ml of acetyl derivative in urine (pH)	% Protein-binding @ blood level 2-20 mg/100 ml
Sulfanilamide	20	1480	1500	534 (7.0)	5-20
Sulfapyridine	10-90	52	33	11 (5.4)	10-45
Sulfathiazole	30	96	180	30 (7.0)	55-80
*Sulfadiazine	15	12	120	115 (7.0)	20-60
*Sulfamerazine	15	34	130	148 (7.0)	80
Sulfisoxazole	30-35	60		60 (5.4)	70-90
Sulfamethoxazole	40	10		30-60 (6.3)	60
*Sulfamethazine	30	75		85 (5.5)	60-80

*Constituents of triple sulfa preparation.

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Electrical stimulation of the conus medullaris and its effect on the neurogenic bladder

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• The treatment of the neurogenic bladder and its complications has preoccupied the neurosurgeon and the urologist for many years. Some solutions have been proposed; none have been too effective. Recently the electrical stimulation of the conus medullaris has been attempted with some success. We reviewed our experience with this surgery and analyzed some of the salient points of other reports. A brief overview of anatomy and physiology of the bladder and its innervation was given.

In the past two years, we have had experience with three cases of implantation of a conus stimulator at the Marshfield Clinic. The first electrical stimulation of the conus medullaris in man was done by Nashold in 1970.[1] Since then well over 30 cases have been reported in the literature, and we would like to relate our experience with this surgery.[2,3]

To comprehend fully the functioning of the stimulator, we will review some neuroanatomical and neurophysiological aspects of bladder function. The bladder has a double innervation system. One can be called intrinsic and consists of a plexus of ganglionic cells, the plexus of Auerbach and Meissner. They cannot accomplish by themselves an efficient contraction of the detrusor muscle. The extrinsic system consists of a center of micturition, situated at the level of the medullary conus. This center placed under cortical and subcortical control is able to induce by itself an automatic function of the bladder, by a reflex arc that is sensory motor. Examples of this are the bladder activity in a baby of 18 months or less and also the activity exhibited by the patient with spinal cord trauma. The center is situated at the level of the sacral cord, the S2, S3, and S4 segments. It occupies the medial ventral part of the cord in contact with the anterior horns.

The afferent pathways of micturition are threefold. First, the sympathetic fibers which use the upper lumbar and lower thoracic spine nerve roots to innervate the bladder in general and the internal sphincter through the superior hypogastric plexus (presacral nerve and hypogastric nerves). Then, the parasympathetic fibers travel with the S2 and S4 roots to innervate the detrusor muscles and internal sphincter via the pelvic nerves. Finally, the somatic fibers of the S3 and S4 roots act upon the external sphincter of the urethra using the pudendal nerves.

Normally the spinal center is under the control of the cortical and subcortical centers of the brain. When this spinal center is released from its influence through lesions of the cord above D12, the center becomes automatic as in early childhood and a spastic bladder usually develops. If the center is destroyed, the bladder usually becomes atonic and without automaticity. However, these conditions are interchangeable.

Case reports

Case 1. A 25-year-old woman was rendered quadraplegic in 1970 from

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a fracture/dislocation of C6 and undisplaced fracture of C7. Rehabilitation was slow and she was able to get good upper extremity function back. She occasionally had urinary calculi and intravenous pyelograms remained normal. In September 1975 she asked for a suprapubic tube because she was contemplating marriage. She then was informed of the neurostimulator. In November 1975 she underwent a laminectomy from T12 to L1 and partial L2 (PM). Mild hypertension was registered during stimulation intraoperatively. Also there were some cardiac irregularities which were treated with lidocaine.

The immediate and late postoperative period were uneventful and the stimulation worked perfectly. On follow-up she was observed to have excellent function of the stimulator; transient fluid collection around the receiver site was noted but subsided spontaneously. The patient had only one episode of pyuria in March 1976, which was treated with sulfisoxazole (Gantrisin®). The patient has been happy with the results.

Case 2. A 31-year-old woman was rendered paraplegic in April 1969 by a compression fracture of T12 with bony displacement of T11 over T12. In April 1969 a revision laminectomy was made at T11-T12. Excision of a herniated disc with fragments with some decompression and biopsy of the cord was performed. She was placed on a regimen of physical therapy for ambulation with braces.

She remained with paresthesias of the lower extremity and groin which gradually decreased, and a suprapubic tube was inserted. The rehabilitation showed good progress with occasional bladder infections, and in April 1975 a large bladder calculus was removed. She was considered for a bladder stimulator although her injury was theoretically at the level of the conus. However, a trial percutaneous electrostimulation in December 1975 showed satisfactory bladder pressures. Therefore, it was decided to attempt stimulation.

In January 1976, the thoracolumbar incision was reopened and a laminectomy (PM) was carried down to the L1-L2 level and the implantation was made 15.5 cm above the distal conus. Scarring above the conus was noticed for 3 or 4 cm. Poor pressures were obtained even at the time of surgery, the highest being 31 cm of water and postoperatively the stimulator did not work. On follow-up, even with a new power unit, the stimulator remained nonfunctional. X-ray films showed the implant to be intact.

Case 3. This 17-year-old woman was rendered paraplegic in 1974 from a T5 injury. Her neurogenic bladder was treated with suprapubic tube drainage. Rehabilitation process was slow with many psychological stresses and the patient was placed in a foster home. Bladder stones were removed in 1975 and she had occasional urinary tract infections. She expressed a wish of trying the stimulator and in January 1977 a laminectomy was made T12-L1 (ML). The small conus was visualized and implantation was made 2 cm above the distal conus with good intra-operative bladder pressure obtained. Postoperatively there were no problems. Stimulation was successful and cystocinegrams showed excellent bladder emptying. Follow-up to this date has been excellent with no problem and good functioning of the stimulator. No new bladder infection has been registered.

Discussion

The surgery consists of a laminectomy around T12-L1, opening of the dura, and visualization of the conus. Then surface stimulation of the conus with readings of bladder pressures are made until a point is obtained where high bladder pressures are measured without too many side effects such as severe spasm, elevation in blood pressure, cardiac irregularities, and the like. Once the area is identified, the bipolar electrodes are implanted and held in place with the help of a silastic band that is wrapped around the conus itself. The dura is closed as water tight as possible, then the wires are brought subcutaneously and connected to the wires from a receptor that is placed at distance in a subcutaneous bed in one of the flanks. The patient, with the help of the staff, chooses the parameters on the power unit that give her the best bladder emptying and stimulates herself on a regular basis.

The reports in the literature concerning bladder stimulators have results comparable to ours and those who have had experience with longer follow-up[2,3] have observed that in the majority of cases the electrical stimulation of the conus maintains itself and seems to indicate that the stimulating electrodes are not displaced with time. Failures in the majority of cases were related to discovery or the development of spasm or sclerosis of the smooth or striated sphincters. In some cases these mechanical troubles were discovered or treated too late, resulting in failures. Although we did not have any male patients, review of the literature points to the fact that female patients have more of a chance of success than men because less problems with dysfunction of the sphincters arise.

Our indications for performing this surgery are compatible with those of others. There are some absolute conditions that must be observed. First, the absence of damage to the conus medullaris. In case 2 there was evidence of this. Percutaneous stimulation was not a good predictor of success and will no longer be an indication for us to perform surgery in cases of conus trauma. The patient must be competent, cooperative and able to assume intellectually and physically his own re-education. Presently we would not operate before the end of the spinal shock phase, though this could be changed in the future. Other indications include absence of ureteral reflux and normal kidney function. Close cooperation with the Urology Department is a prerequisite for good care and selection of patients.

Summary

We have reviewed our experience with three cases, two of which obtained excellent results. What we propose in this discussion is functional neurosurgery rather than destructive neurosurgery. For the first time a voluntary act is transmitted to a section of the spinal cord and this is, we think, a major step forward. Would walking paraplegics be the next step?

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Pathologic classification and incidence of renal glomerular disease: a Wisconsin renal biopsy study

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SINCE 1970 WE have been processing and interpreting renal biopsies submitted to us from the renal unit of University of Wisconsin Hospitals as well as from hospitals throughout Wisconsin and northern Illinois. Over 1,000 specimens have been examined during this interval, more than half of which have been sent from referring physicians outside of UW Hospitals. Upon request, we provide a biopsy kit to referring pathologists with instructions indicating how to prepare divided portions of a renal biopsy for submission to our laboratory. Out of our program of combined and correlative light, immunofluorescence and electron microscopic examination and interpretation of renal specimens has emerged a variety of original observations regarding diagnostic renal pathology and natural history and response to therapies in selected renal diseases.[1-14] In addition, our nephrology service, research and training program is participating in the National Nephrotic Syndrome Controlled Therapeutic Study administered by Dr Cecil Coggins at the Massachusetts General Hospital in Boston which provides elective opportunity for Wisconsin patients and physicians to be part of this important venture.

Of particular relevance to the present report is the contribution our cumulative experience with renal biopsies can make regarding comparative frequency of different renal diseases among biopsied patients in the Wisconsin area. Furthermore, this presentation provides an opportunity to clarify pathologic features of different glomerular diseases and to indicate some of the more salient correlative clinical features. Unfortunately because of page limitations we are not able to present the full range of our findings in this particular report, but must briefly summarize the important features. For those who are interested in reading a more comprehensive analysis of the results of our Wisconsin renal biopsy program, we have prepared a more detailed, complete, and fully illustrated manuscript which may be obtained upon request to the authors. It is hoped that the comprehensive review of pathologic terminology, diagnostic classification, and indication of frequency of occurrence of renal disease indicated in this supplementary more complete report, available upon request, may serve as a guide to Wisconsin nephrologists, pathologists, and other physicians wishing to utilize our routine and special histopathology services.

Materials and methods

Over a five-year period from January 1971 to December 1975 some 700 consecutive renal specimens were examined and recently reviewed for the purpose of this report. The biopsied population is composed of patients from Wisconsin, northern Illinois, and Iowa who either were admitted to University of Wisconsin Hospitals or had their renal biopsy performed locally and mailed to us for processing. For this report, the results of examination of 507 cases are briefly presented. Since the objective of this report is to present an abbreviated analysis of our biopsy experience with glomerular disease, a minority of cases consisting of either inadequate specimens or cases with diagnoses of interstitial nephritis, cystic disease, cortical necrosis, or vasomotor nephropathy (acute tubular necrosis) have been excluded. In addition, patients who had more than one renal biopsy during this interval are counted as only one case and in these instances the final best diagnosis was determined by summary review of all the specimens available in the particular case. A few entities, not primarily glomerulopathic, are included because of their relevance to differential diagnosis of glomerular diseases: these include sarcoidosis, reflux nephropathy, chronic pyelonephritis, and various forms of transplantation rejection and vasculitis. The classification utilized to categorize renal lesions is a modification of that presented in greater detail elsewhere[8] and utilizes, in the main, histopathologic criteria with purposeful exclusion of clinical terminology as much as possible (Table 1). The purpose of this fundamental approach is to provide a roster or catalogue of apparently distinct renal glomerular alterations as observed by light, immunofluorescence, and electron microscopic examinations and then to relate the pathologic findings with clinical features of disease to ultimately achieve the best or most appropriate diagnosis.

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Publication support provided.
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Clinicopathologic correlations reveal on the one hand that a variety of different clinical entities may present within a single histopathologic category such as Henoch-Schoenlien nephritis, Berger's IgM nephropathy, lupus nephritis, polyarteritis nodosa, and focal embolic glomerulonephritis presenting with focal segmental proliferative glomerular lesions. Furthermore, different pathologic entities may be associated with not otherwise distinctive clinical features such as minimal glomerular change disease, membranous glomerulonephritis, and focal sclerosing glomerulonephropathy presenting with nephrotic syndrome. In some instances where clinical features do not serve to further clarify a pathologic finding the cases will be categorized for purposes of this report as a descriptive pathologic alteration "not otherwise classified" (NOC).

The general modes of clinical presentation of each pathologic category of renal disease are indicated in Table 1. Criteria for nephrotic syndrome comprised proteinuria equal to or greater than 2.5 gm per 24 hours or at least two of the following: history of proteinuria, edema, serum albumin less than 3.5 mg/100 ml and serum cholesterol greater than 300 mg/100 ml. Hematuria, implying nephritic rather than nephrotic disease, signifies greater than 10 red blood cells per high-power field in the urine sediment. Patients exhibiting both nephrotic syndrome and significant hematuria are referred to as having mixed nephrotic-nephritic clinical presentation.

The precise procedures for processing specimens of biopsied kidney for routine light and special immunofluorescence and electron microscopy are presented elsewhere in great detail.[8]

Table 1—Frequency of occurrence, clinical pathological diagnosis, and major clinical signs of kidney disease

	NO. CASES	% OF TOTAL	NS	HEM	M	N
(1) Minimal Glomerular Change Disease:	36	7.1	24	1	—	2
(2) Membranous Glomerulonephritis:	26	5.1	13	3	4	1
(3) Mesangiopathic and Focal Proliferative GN:						
a) Focal Proliferative Mesangial IgA-IgG Glomerulonephritis:	8	3.5	9	3	3	5
b) Henoch-Schoenlein Focal Proliferative Glomerulonephritis:	6	1.2	1	3	—	—
c) Mesangiopathic and Focal Proliferative GN NOC:	20	3.9	1	6	2	3
(4) Focal Glomerular Sclerosis:						
a) Focal Sclerosing Glomerulopathy:	34	6.7	16	4	5	7
b) Focal Global Glomerulosclerosis:	12	2.4	4	1	1	1
c) Focal Glomerular Sclerosis NOC:	4	0.8	1	—	—	1
(5) Diffuse Proliferative Glomerulonephritis:						
a) Diffuse Proliferative Glomerulonephritis:	6	1.2	2	1	2	—
b) Mesangioproliferative Glomerulonephritis:	5	1.0	2	2	1	—
(6) Membranoproliferative (Mesangiocapillary Proliferative) GN:						
a) Dense Deposit Disease (MbPGN, Type II):	3	0.6	2	—	—	—
b) Membranoproliferative GN, (Type I):	10	2.0	3	3	—	3
c) Mixed Membranous and Proliferative GN (MbPGN, Type III):	15	3.0	1	3	6	1
d) Membranoproliferative GN NOC:	16	3.1	4	—	4	1
(7) Crescentic (Extracapillary) Proliferative Glomerulonephritis:						
a) Goodpasture's Crescentic Proliferative GN:	2	0.4	—	2	—	—
b) Crescentic Proliferative and Necrotizing GN:	1	0.2	1	—	—	—
c) Crescentic Proliferative GN NOC:	23	4.5	1	10	4	4
(8) Glomerulonephritis with SLE:						
a) Mesangiopathic and Focal Proliferative GN:	19	3.7	4	6	4	2
b) Diffuse Proliferative GN:	11	2.1	2	1	2	1
c) Membranous Glomerulonephritis:	8	1.6	2	—	2	3
d) Membranoproliferative Glomerulonephritis:	9	1.8	1	—	3	3
e) Chronic Glomerulonephritis:	7	1.4	—	—	3	3
f) Glomerulonephritis with SLE NOC:	9	1.8	1	—	2	1
(9) Chronic Glomerulonephritis:	35	6.9	4	1	9	2
(10) Chronic Lobular Glomerulonephritis:	1	0.2	—	—	—	—
(11) Amyloidosis:	8	1.6	—	—	—	—
(12) Intercapillary and Membranous Diabetic Glomerulosclerosis:	4	0.8	5	—	—	1
(13) Granulomatous (Wegener's) Glomerulonephritis:	1	0.2	—	1	—	—
(14) Vasculitis: Hypersensitivity and polyarteritis nodosa:	0	—	—	—	—	—
(15) Hereditary Glomerulonephritis (Alport's Syndrome):	5	1.0	1	1	1	1
(16) Fabry's Disease (glomerular-vascular lipidosis):	1	0.2	—	—	—	1
(17) Chronic Pyelonephritis:	19	3.7	—	—	1	2
(18) Cryoglobulinemic GN:	3	0.6	—	—	3	—
(19) Stalk Glomerulonephropathy (*mild* nonspecific mesangial cellularity or sclerosis:	24	4.7	9	8	3	—
(20) Transplant Rejection:						
a) Hyperacute:	1	0.2	—	—	—	—
b) Acute:	41	8.1	—	—	—	—
c) Chronic:	7	1.4	—	—	—	—
d) Transplant Rejection: NOC:	27	5.3	—	—	—	—
(21) Sarcoidosis:	2	0.4	—	1	—	—
(22) Reflux Nephropathy:	2	0.4	—	1	—	—
(23) Not Classified:	26	5.1	—	—	—	—
TOTAL NUMBER OF CASES: 507						

GN = Glomerulonephritis; SLE = Systemic Lupus Erythematosis; NS = Nephrotic Syndrome; HEM = Hematuric; M = Mixed Nephrotic and Hematuric; N = Neither; NOC = Not Otherwise Classified

Results and discussion

A total of 507 cases was analyzed for this report. In Table 1 are indicated the frequency of occurrence of each pathologic category of renal disease and the major clinical signs of proteinuria, hematuria, or nephrotic-nephritic syndrome. Those

instances where clinical data were insufficient for assessment were not included in tabulation of clinical signs. Some patients may have had proteinuria less than the cut-off point for nephrotic syndrome and thus do not appear in the tabulation of clinical signs.

About 64% of the renal biopsies reviewed in this report fall into eight major categories of glomerular alterations; these are minimal glomerular change disease (7%), membranous glomerulonephritis [GN] (5%), focal proliferative GN (9%), focal glomerular sclerosis (10%), membranoproliferative GN (9%), crescentic proliferative GN (5%), systemic lupus erythematosis [SLE] nephritis (12%), and chronic GN (7%). Thus, patients who have significant proteinuria or hematuria will have a reasonably high likelihood of falling into one or another of these major categories. A thorough clinical history as well as light, immunofluorescence and electron microscopy evaluation of the renal biopsy should lead to a correct or best diagnosis in most cases. Biopsy diagnosis is essential since diseases such as minimal glomerular change disease and early membranous or focal sclerosing glomerulopathy frequently cannot be differentiated by clinical features. Furthermore, renal biopsy can be very helpful in distinguishing diffuse and focal proliferative forms of hematuric disease or diffuse proliferative glomerulonephritis with temporary renal failure from rapidly progressive crescentic glomerulonephritis.

Generally, patients with diffuse or focal proliferative as well as crescentic glomerular lesions will present with nephritic symptoms including hematuria with less significant, negligible, or variable proteinuria. Those patients presenting with glomerular capillary membrane lesions with little or no proliferative alterations such as minimal glomerular change disease, membranous glomerulonephritis, amyloidosis, and diabetic glomerulosclerosis will present with proteinuria or nephrotic syndrome with less significant or negligible hematuria. Finally, some diseases such as lupus nephritis, membranoproliferative glomerulonephritis, and cryoglobulinemic glomerulonephritis, which are characteristically mixed proliferative and capillary membrane glomerular lesions, may be expected to present with a mixed clinical syndrome consisting of significant hematuria and nephrotic proteinuria.

Another observation emerges from a study of the type presented here; the use of correlative light, immunofluorescence, and electron microscopy though costly and time consuming, is extremely valuable in establishing more secure and reliable diagnoses. Two common examples of illustrative circumstances support the above statement. In very early instances of nephrotic membranous glomerulonephritis, light microscopic alterations may be of insufficient magnitude to be detected and a potentially erroneous diagnosis of minimal glomerular change disease would be made. However, by immunofluorescence microscopy diffuse fine granular glomerular capillary deposits of IgG and C3 as well as tiny epimembranous electron dense deposits observed by electron microscopy would provide the proper diagnosis of membranous glomerulonephritis in such a case. Another example is a nephrotic adolescent who by light microscopic examination of a renal biopsy has apparent mild mesangial matrix expansion constituting "minimal glomerular alterations" considered compatible with minimal glomerular change disease. In this case, however, immunofluorescence microscopy might reveal local granular or globular glomerular capillary deposits of IgM, perhaps some IgG, and C3. Ultrastructurally, a single glomerular capillary loop is observed to contain a large dense deposit intermixed with lipid vacuoles and cytoplasmic organelles and to be associated with sclerotic adhesion to the adjacent Bowman's capsule. These are features of focal sclerosing glomerulonephropathy which modify the original erroneous diagnosis of minimal glomerular change disease in this example.

Conclusion

We hope this brief review, revealing the contributions a central Wisconsin comprehensive renal biopsy interpretation service may provide, has been informative. If more detailed information is desired, you may request a copy of the more extended and explanatory manuscript from the authors.

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Reappraisal of the management of intracranial aneurysms

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• The recent neurological literature is replete with articles on varying individual factors and therapeutic regimens to lessen the serious consequences of subarachnoid hemorrhage secondary to a ruptured intracranial aneurysm. Each of these treatment modalities will be briefly reviewed in order to judge their merit and applications.

THE MOST COMMON etiology of spontaneous subarachnoid hemorrhage in the adult is the ruptured intracranial aneurysm. The basic pathophysiology of such an aneurysm is a focal defect in the internal elastic membrane of an intracranial vessel. As this defect enlarges the total force in this region increases resulting in progressive growth and the increasing potential of a spontaneous hemorrhage. The attending physician is then presented with a very seriously ill patient to whom many medical personnel attach a grave prognosis. However, recent developments in the management of this disease state offer a significant reduction in mortality and morbidity.

Most neurosurgeons use a grading classification based on neurologic symptomatology as outlined by Botterell in determining their clinical management. A Grade I patient is essentially intact, usually only with headache. A Grade V patient is moribund and essentially preterminal. A patient who remains moribund for 24 to 36 hours has a survival rate of approximately 8-12%.[1] Recovery before that time with only minor symptoms would indicate a one-year survival rate of 40-50%. More important is that approximately 60-70% of patients with aneurysm demonstrated on angiography will have a second and usually more severe hemorrhage usually in the second or third week after the first hemorrhage.[2]

The neurosurgical consensus is that treatment of an aneurysm before massive hemorrhage provides a much more favorable outcome with a recent series employing microsurgical techniques reporting a mortality of 1 to 3%. This consideration emphasizes the significant advantage of early recognition. In this respect, the attending physician must be acutely aware of warning signs before the catastrophe of major hemorrhage ensues.

Headache of a sudden severe onset in an adult patient without a significant history of such complaints must be considered a subarachnoid hemorrhage until proven otherwise. A frequent problem is confusing an enlarging or leaking aneurysm with the migraine syndrome. Less frequently the physician may be warned by the onset of an extraocular nerve paresis, eye pain, facial pain, or a visual field defect. A third group of patients may show signs of focal neurologic deficit either motor or sensory as the result of temporary ischemia. This group usually has associated generalized headache, nausea, lethargy, and possibly photophobia. In all of these instances a careful spinal tap will allow the alert examiner to refer the patient for early definitive care. In a study of 112 cases, the average interval from onset of warning signs to major hemorrhage was 20.7 days.[3]

Primary Management

Although initially one is usually presented with a seriously ill patient, very few of these represent a surgical emergency (intracerebral hematoma, subdural hematoma, and the like). Initially it is preferable for the patient to remain in his local facility at complete bed rest receiving light sedation and analgesic agents for one to two days rather than undergo immediate transfer to a major facility. This attitude is taken, understanding well the reluctance of the attending physician to have a patient develop catastrophic complications prior to accomplishing neurosurgical consultation. However, early in the course of the illness little is to be gained and potentially much can be lost by such a move.

Following this initial state most major centers prefer to wait five to seven days or longer before contemplating a surgical approach. During that time, one is faced with a patient manifesting varying effects of cerebral edema, vasospasm, chemical meningitis, inappropriate antidiuretic hormone syndrome, increased intracranial pressure, and communicating hydrocephalus. Each of these entities must be therapeutically approached as only part of the total problem for they all potentially contribute to a vicious cycle of impaired cerebral function and hemodynamics. For example, the subarachoid hemorrhage results in the release of vasoconstrictor substances with resultant cerebral ischemia and its sequelae of cerebral edema. Communicating hydrocephalus, if present, also results in increased intracranial pressure and decreased cerebral perfusion pressure and

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therefore cerebral hypoxia and edema. Thus it can be easily seen that each area of dysfunction contributes to the reverberating cycle of progressive cerebral dysfunction and damage.[4] This pattern does not mention the greatest threat to survival which is the likelihood of recurrent hemorrhage.

The clinician then must carefully monitor the patient's neurologic condition in order to apply the proper therapeutic measures to reverse these deleterious effects and to prevent recurrent hemorrhage.

One of the first problems that the clinician faces is control of blood pressure and even the temptation to achieve a relatively hypotensive state, thus retarding the incidence of recurrent hemorrhages. The evidence at this time indicates that lowering of blood pressure presents many significant risks. Patients with subarachnoid hemorrhage both develop alterations of intracranial resistance vessels and lose regional areas of cerebral vessel autoregulation and thus become pressure dependent. Hypotensive therapy then can result in cerebral ischemia and perpetuation of the previously described "vicious cycle." These facts certainly do not preclude the need for blood pressure control in certain instances, but these cases must be chosen carefully.

Many clinicians favor the use of steroids in these patients whereas others feel that their beneficial effects of edema reduction are limited and the risk of gastrointestinal bleeding interdicts their use. It is a personal belief that steroid therapy (dexamethasone, 4 mg intramuscularly every six hours) with antacid therapy (Maalox®, 30-45 ml every three to four hours) does not effectively reduce cerebral edema in this setting, but it does offer protection by stabilization of the cell membrane and lysosomes.

Antifibrinolytic agents such as epsilon amino caproic acid (Amicar®) are used to delay the recurrence of hemorrhage. The premise behind the use of these agents is that following the initial hemorrhage a fibrin clot is formed over the bleeding site on the aneurysmal sac. This clot is then protective but will undergo dissolution by circulating fibrinolysins in six to eight days. Thus to prevent or delay this occurrence, antifibrinolytic agents are used. Although the experimental evidence for such an action is not clear-cut, clinical experience in many centers suggests a protective influence from such therapy. The dosage level must be large, and the recommended schedule is a loading dose of 24 gm administered at 4 gm every three hours times eight, then followed by a maintenance level of 16 gm in daily divided doses of 4 gm every six hours intravenously or orally.[5]

If the patient manifests inappropriate antidiuretic hormone response with secondary hypo-osmolarity of serum and hyponatremia, fluid restriction of 800 to 1200 ml daily is recommended. Rarely is more aggressive therapy required.

Early communicating hydrocephalus is gaining greater significance as an etiology of progressive neurologic deterioration in these cases. Repeated lumbar punctures are a rather nonphysiologic method of treatment and are contraindicated in the face of marked intracranial pressure or mass lesion. Once these factors have been excluded the patient may require an external continuous lumbar drain to relieve this problem.

Osmotic therapy to reduce the cerebral edema also may be required and we prefer to use continuous intravenous 10% glycerol infusions with associated monitoring of intracranial pressure and serum osmolarities. The preference for glycerol is based on the very low incidence of "osmotic rebound" within the intracranial cavity as well as some experimental evidence indicating that it reduces changes in the aerobic metabolic cycle in the brain.[6] It is also for this latter reason that barbiturate sedation (phenobarbital) is recommended.

In order to effectively apply these therapeutic measures, an informative monitoring system must be used. After angiographic diagnosis of the source of the subarachnoid hemorrhage has been established, we place the patient on an on-line computer-assisted monitoring system giving continuous readings of intracranial pressure, somatosensory evoked potentials, EEG, transcranial and transthoracic impedance, P_aCO_2 levels, blood pressure, pulse, temperature and respiratory patterns. Regional cerebral blood flow data by means of nonintrusive radioisotope techniques will soon be included in this monitoring scheme. If one or more of the monitoring factors reveals significant changes, then an early alteration in therapeutic management can be applied allowing a longer recovery period for the patient and greatly reducing the risks of surgery. At the present time, the pathophysiological mechanisms involved in the frequently encountered increase in resistance by portions of the intracranial vasculature often termed "cerebral vasospasm" is incompletely understood. Numerous investigators have proposed a wide range of therapeutic modalities for relief of the potentially catastrophic complications of which none has achieved significant acceptance.[7] However, the previously described monitoring system will permit implementing newer methods of therapy in a more controlled manner.

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Meniere's disease

Changing emphasis in therapeutic options and goals

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IN THE LAST FIVE to ten years there have been distinct changes in the clinical perception of Meniere's disease: its diagnosis, prognosis, treatment goals, emphasis, and therapeutic options.[1]

Meniere's disease is much more common than previously thought. The incidence is 46/100,000 which roughly means 100,000 patients in the United States yearly.[2] Meniere's disease is four times more common than otosclerosis. It also is more common than all laryngeal carcinomas, all salivary gland tumors, both benign and malignant, acute nephritis, and pernicious anemia.[2]

The classic standard description of symptoms includes episodic vertigo, fluctuant sensorineural hearing loss, tinnitus, and aural fullness or pressure. It should be emphasized that there are variants of Meniere's disease which were not included in the above incidence statistic, but are defined as subclasses of Meniere's disease by the American Academy of Ophthalmology and Otolaryngology.[3] These are cochlear Meniere's disease in which there is no vertigo, and vestibular Meniere's disease in which there is no hearing loss. These two subclasses usually progress to full Meniere's disease with time. The hearing loss in the early stages of the disease is characteristically a *low* frequency loss involving the speech frequencies and impairing the patient's understanding of what he hears. Late in the course of the disease, the hearing loss progressively gets worse and may not fluctuate. The audiometric glycerol test can help verify the presence of excess fluid in the inner ear, endolymphatic hydrops. When it is positive, it is not only helpful in the clinical-audiometric diagnosis of Meniere's disease (hydrops), but also it is helpful in prognosticating which patients will benefit from endolymphatic sac decompression and drainage with a unidirectional inner ear valve. It is imperative to consider, in the differential diagnosis, lesions of the internal auditory canal or cerebellopontine angle or other central nervous system lesions.

Treatment goals also have shifted in the last decade.[1] Previously, the major emphasis of therapy was "relief" of the vertigo, with little if any attention directed towards the hearing loss. Now we know that during the acute exacerbations, the vertigo and associated nausea and vomiting can be controlled by intravenous diazepam (Valium®) or droperidol (one of the best vestibular suppressants) and bed rest. It also is accepted that if nothing is done, the vertiginous crisis might subside in 24 hours or less. If recurrent episodes of vertigo are interfering with the patient's day-to-day functions and the patient has already nonfluctuating hearing loss, then vestibular nerve section or labyrinthectomy will invariably eliminate the vertigo.[1] It should be emphasized that the vertigo component of Meniere's disease runs its course and "burns" itself out in the first few years in almost 80% of patients. What many people have long reported as effective therapies for controlling vertigo in Meniere's disease (60-80% success rates) is nothing more than the natural course of the vertigo.

The emphasis in therapy is now directed toward the hearing loss. The AA00 criteria for reporting lists four grades of results. The first three all require absence of vertigo, but Class A requires 15% improvement in hearing, Class B stabilization of hearing and Class C, loss of hearing with absence of vertigo. Class D is a failure. This AA00 reporting system gives strict criteria for reporting which make comparison of results of different therapeutic modalities possible.

The therapeutic options in Meniere's disease advocated in the past are many and varied. It is now pretty well accepted that no currently available medical treatment can alter the natural course of the disease particularly the hearing loss.[1] Diuretics, low-salt diet, and vestibular suppressants may slow the process in early cases, but they are ineffective for long-term therapy[1] as is histamine,[5] nicotinic acid,[5] vasodilators, lipoflavinoids,[5] vitamins[5] and beta histidine hydrochloride (SERC®).[1]

Surgical intervention of the endolymphatic sac (ELS)[4] has emerged in recent years as the most effective therapy for Meniere's disease. This ELS[6] is a pouch of the inner ear which is intimately involved in the reabsorption of endolymph formed elsewhere in the inner ear. In Meniere's disease the ELS shows histological changes in the lining epithelium which would interfere with its ability to absorb endolymph.[6] This finding is corrob-

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orated by animal experiments which show that animals deprived of their ELS function develop endolymphatic hydrops; the histopathologic correlate of Meniere's disease.[6] The goal of sac surgery is to provide drainage of the excess inner fluid when it is under increased volume and pressure. This allows the closed inner ear fluid system a mechanism of fluid escape (a one way valved mechanism). One operation involves a Silastic sheeting wick from the ELS to the mastoid air cells with the following results.[4]

"Thirty-five patients with Meniere's disease underwent endolymphatic sac decompression and drainage with a Silastic sac-mastoid directed outflow device. On the basis of patients' responses to a questionnaire and on analysis of preoperative and postoperative audiometric studies, we found the method to be an effective means for conservation or improvement of hearing and for relief of vertigo in patients with positive glycerol tests.

Of the 35 patients, eight had negative glycerol tests and did not benefit from surgery. Of the 27 patients with positive glycerol tests, 70.4% (19) had no further vertigo, and 18.5% (5) had decreased frequency or severity of attacks (an overall relief of vertigo in 88.9%). Hearing was improved in 16 (59.2%) and stabilized in 5 (18.5%). Subjectively, 85.2% (23/35) of the patients were satisfied with the hearing results of their operation."

More recently, a unidirectional inner ear valve implant which can function as an escape valve has been developed for use in the inner ear.[7] It is modified from the Krupin eye valve for anterior chamber surgery for intractable glaucoma. The one-year short-term results with this new inner ear valve implanted in the ELS are much better than with the Silastic sheeting;[8] 80% improvement in hearing in patients who had greater than 50% hearing loss and intractable vertigo. In the past these patients were destined for labyrinthectomy or other destructive procedures.

In summary, the emphasis and treatment goals are now clearly on the hearing component with awareness that the vertigo will be relieved in about 80% of cases either in the natural course of the disease or with ELS surgery aimed at conservation of hearing. If this fails, destructive surgical methods are still available to eliminate the vertigo.

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ABSTRACT/ WISCONSIN AUTHORS

Implications of the ^{99m}Tc diphosphonate bone scan on treatment of primary breast cancer

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The ^{99m} technetium diphosphonate bone scan can help identify primary breast cancer patients with a high risk of developing metastatic disease. Bone scans are more accurate and different from conventional radiographs. The radiation dose of a bone scan to the patient is similar to that of a radiologic skeletal survey, so repeated bone scans of the same patient can be made. A scan can change from negative to positive in the absence of clinical or radiologic evidence of local recurrence or distant metastases. The availability of ^{99m}Tc-labeled phosphate and diphosphonate compounds has made high quality bone scans possible for all hospitals. In three recent studies, 6-30% of patients with clinically apparently localized breast cancer (stages I and II) and negative radiologic surveys had positive bone scans. A positive bone scan, whether initially positive or due to conversion of a previously negative study, is associated with poor short-term prognosis. Rapid conversion indicates progression of occult skeletal metastases, and the prognosis is very poor.

An isotope bone scan should be an essential part of the initial workup of patients entered into postmastectomy adjuvant therapy trials. It is possible to identify patients with occult bone metastases at the time of mastectomy and to follow the progression of skeletal metastases in asymptomatic patients during the 'disease-free' interval after mastectomy. Treatment failure can be detected earlier with bone scans of patients receiving adjuvant therapy than with radiographs.

The bone scan is a marker which can detect the presence of tumors and document the biologic behavior of occult micrometastases with a sensitivity similar to biochemical and immunologic markers. Studies of the diagnostic and prognostic significance of serial bone scans in patients receiving adjuvant chemotherapy will permit the relationship of bone scans to clinical and pathological factors and to tumor markers to be evaluated and related to the patient's clinical course, therapeutic response, and survival. ■

Presentation and prognosis of sarcoidosis in a predominantly white, rural population

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• A predominantly white, rural population meeting the criteria for the diagnosis of sarcoid were analyzed to determine whether the characteristics and prognosis of the disease differed from large urban populations with a large black population. Of the 104 patients studied, only 7 were black. The initial extent of disease upon presentation as evaluated by chest roentgenograms, organ involvement, and lymph node enlargement were similar to previously reported series. In addition, the number of patients improving, worsening, or remaining stable was again similar. Some differences were noted including a more even sex distribution and a greater percentage of older women. These findings suggest sarcoidosis is similar in presentation and prognosis no matter what the population involved.

THE INCIDENCE, epidemiology, and clinical presentation of sarcoidosis has been the subject of many studies.[1-3] It was generally felt that the clinical course and the prognostic outlook was less favorable in a nonwhite population.[4] However, recently this impression has been challenged.[5] In reviewing population studies of sarcoidosis from London, New York, Paris, Los Angeles, and Tokyo, little differences were found in the clinical characteristics of the disease between populations of different racial and ethnic backgrounds.

In our experience at the University of Wisconsin Center for Health Sciences (UWCHS), it was felt that in its predominantly white, rural patient population the disease was similar in presentation, course, and prognosis to that of the largely nonwhite, big city populations. It was to evaluate this clinical impression that this study was undertaken.

Method

A retrospective analysis of the patient population diagnosed as having sarcoidosis in the period of 1956-1972 was made. The patients whose records were considered in this study were derived from the University of Wisconsin Hospitals. The patients included were: (1) those with morphologic evidence of noncaseating granulomas in organs other than the liver which could not be ascribed either to mycobacterial or fungal infections, and (2) those without biopsy confirmation but who met the criteria of Winterbauer and coworkers.[6]

Pulmonary functions were done by standard laboratory techniques[7] with predicted values of normal from standard sources.[7-8] Only the functions of those patients who had the first study within six months of the appearance of the clinical problem leading to the diagnosis of sarcoidosis were considered. The initial vital capacity (VC), total lung capacity (TLC), diffusion capacity (DL_{CO}), and arterial PO_2 (PaO_2) were compared with the latest tests available. A significant change was considered to be 10% of the initial value in either direction.

The earliest chest roentgenogram following the recognition of the disease was reviewed by the three authors and classified according to Siltzbach.[1] Stage I describes the presence of hilar adenopathy only; Stage II includes hilar adenopathy and parenchymal infiltration; and Stage III has only parenchymal disease. Patients with no evidence of thoracic involvement were classified as Stage 0. The latest films, when available, were compared to the initial study to determine the progress of the disease.

Results and discussion

While the incidence of sarcoidosis at the UWCHS may not be as great as it is in some larger city hospitals, the disease is certainly not rare. Of the 104 patients studied, only a small percentage was black (7%). It is this predominantly white population that reportedly has more benign disease.[4] In Table 1 the common clinical characteristics are shown, and in comparison with other studies[1,3,9] show similar general characteristics regarding the organ involvement upon presentation to a medical center. Using the same staging criteria as Siltzbach, there is no major difference in the extent of the disease on presentation as shown in Table 2.

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However, some differences in chemical abnormalities were present. In addition, there was a more even distribution of University Hospitals patients below and above the 40-year-old age level.

Accepting that there is a factor of observer difference in judging progression of disease by different observers at different institutions, it still seems valid to compare the roentgenographic course from University Hospitals patients with that of Siltzbach[1] (Table 3). A greater percentage of Siltzbach's patients in all three stages demonstrates improvement. More of our Stage I patients seemed to worsen, with relatively similar numbers in Stage II and Stage III. While only a general impression can be reached, it seems probable that the predominantly black population did not do worse, and perhaps it did better than the predominantly white population studied at UWCHS.

Pulmonary function changes in Stage II and III (Table 4) suggest that a significant number, usually more than half of the patients studied, either stayed the same or worsened by 10%. This is true for all but two parameters evaluated. Since these individuals began with roentgenographic evidence of parenchymal involvement, this lack of improvement is further support that there can be significant, probably permanent, pulmonary damage in this population.

Conclusion

The main objectives of this study were to study the characteristics of sarcoidosis in a predominantly white, rural and small town urban population and to then determine whether this population differed in characteristics and severity of disease from the large urban population with a large black population so often studied. It seems that generally there are little differences in presenting symptoms, lung involvement, or involvement of other organs. The main differences seem to be a more even sex distribution and

Table 1—Clinical Characteristics (n = 104)

	%
I. Presenting manifestation	
Abnormal chest film	37
Cough	18
Dyspnea	18
Joint symptoms	17
Fever	13
II. Extrathoracic organ involvement	
Lymph nodes	18
Liver	13
Eye	12
Skin	9
Spleen	7
III. Abnormal initial pulmonary function	
Vital capacity (<80% predicted)	24
Diffusion capacity (<80% predicted)	47
PaO_2 (<80 mmHg)	62

Table 2—Comparison between UWCHS study and Siltzbach et al[1] in regards to some general population characteristics

	SILTZBACH No.	SILTZBACH %	UWCHS No.	UWCHS %
Number studied	311		104	
Race:				
White	111	(35)	97	(93)
Black	146	(47)	7	(7)
Puerto Rican	54	(17)	0	(0)
Age: <40	221	(71)	52	(50)
>40	90	(29)	52	(50)
Increased globulin	158	(61)	30	(29)
Increased calcium	33	(14)	29	(28)
Chest radiogram:				
Stage 0	126	(8)	13	(12)
Stage I	133	(43)	39	(38)
Stage II	108	(35)	26	(25)
Stage III	44	(14)	26	(25)

Table 3—Comparison between roentgenographic changes; reported by Siltzbach and UWCHS study

	SILTZBACH	UWCHS
STAGE I		
% Improving	73	47
% Worsening	7†	34
% Stable	17	19
STAGE II		
% Improving	68	48
% Worsening	26†	26
% Stable	6*	26
STAGE III		
% Improving	62	54
% Worsening	30†	21
% Stable	8*	25

†Those who died were placed in this category

*Calculated by subtracting available data from 100%

Table 4—Pulmonary function direction of change by Stage

	STAGE I				STAGE II				STAGE III			
Average length of follow-up	5 Months				16 Months				3 Years			
Number studied	4 VC*	4 TLC†	3 DL‡	1 P02	13 VC	12 TLC	13 DL	8 P02	14 VC	13 TLC	11 DL	7 P02
Improved	0	1	2	0	6	8	8	4	6	4	4	2
(%)	(20)	(25)	(67)	(0)	(46)	(67)	(62)	(40)	(43)	(31)	(36)	(29)
Worsened	1	0	1	0	0	0	1	4	2	4	2	2
(%)	(25)	(0)	(33)	(0)	(0)	(0)	(8)	(50)	(14)	(31)	(18)	(29)
Stable	3	3	0	1	8	4	4	0	6	5	5	8
(%)	(75)	(75)	(0)	(100)	(54)	(33)	(30)	(10)	(43)	(38)	(46)	(42)

*Vital capacity
†Total lung capacity
‡Diffusion capacity of the lung

a second incidence peak age group at age 50 composed mostly of white women. Also some basic differences in prevalence of hypercalcemia and hypergammaglobulinemia were noted. These findings support the concept that sarcoidosis is basically the same regardless of population source within the United States.

ACKNOWLEDGMENT: The authors wish to thank all the Wisconsin physicians who referred and care for many of the patients reported here.

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ABSTRACT/ WISCONSIN AUTHOR

A new technique for rapid endoscope-assisted intubation of the small intestine

DONALD D DOUGLAS, MD and JOHN F MORRISSEY, MD, University of Wisconsin Medical School, Madison, Wis: *Arch Surg* 113:196-198 (Feb) 1978

This article described a simple method for rapid intubation of the small intestine that was successful in 13 out of 14 attempts. A forward-viewing fiberscope, two endoscopic biopsy forceps, five rubber bands, and the tube to be positioned are required for the method. It should have broad application for the passage of tubes for small intestinal decompression, jejunal feeding, jejunal biopsy, and biliary and pancreatic drainage studies. —VSF ■

Cardiac rehabilitation in Europe and America

Dieter M Voss, MD, Marshfield, Wisconsin

IDEALLY CARDIAC REHABILITATION should be a process that begins in childhood with a program of prevention rather than one that is necessary following myocardical infarction.

Of people in this country who suffer a heart attack, about one half never make it to a hospital alive. For those that do, a long process begins that should end with the patients rehabilitated to the extent they can return to a useful life.

In Marshfield the patient usually is kept under very close observation for the first few days after his/her coronary; but if the patient does well, he/she may progress to care on the floor with telemetry. Cardiac rehabilitation begins with graduated light exercise as soon as possible after the acute phase. By the time the patient is ready for discharge he/she is exercising large muscle groups. Unfortunately at this point the patient usually is given instructions for a continuing program he/she can carry out at home and then given an appointment to return in four to six weeks for a followup visit. There are no facilities to carry out intensive rehabilitation in a controlled environment, and in Marshfield we have nothing such as a YMCA or even an enclosed mall where a program of graduated exercise can be carried out in bad weather.

Doctor Voss

On the other hand, the medical community in West Germany has taken a different approach under the premise that many heart attack victims can be rehabilitated to their previous occupations.

The cost of medical care in West Germany is the highest per capita of any nation in the world. Large clinics completely financed by the health care system have been developed with the goal of rehabilitating cardiac patients.

The patients are referred to these centers when they are discharged from the acute hospital, usually after a hospitalization that is twice as long as one in the United States. A right heart catheterization with exercise testing is done on admission and again at discharge.

Under careful supervision with telemetry and constant monitoring the patients are led through a difficult program of graduated exercise which increases the heart rate to a suitable level to produce conditioning. The program includes hiking, group exercising, and other strenuous activities. The cardiac strain is sufficient so there are instances of cardiac arrest requiring cardiopulmonary resuscitation on occasion. The time required to achieve rehabilitation may be months, but this is felt to be justified because of the very high percentage of patients who can be rehabilitated to a self-sustaining occupation. The net result on the national economy, it is hoped, is a gain by the rehabilitation of the patient. ■

Presented before the Wood County Medical Society, January 19, 1978, in conjunction with and cosponsored by the Marshfield Clinic who has certified one hour of Category I credit toward AMA-PRA for those physicians attending.

Prenatal diagnosis by amniocentesis —a patient survey

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• A pilot survey of patients who had had genetic amniocentesis and had been found to have an unaffected fetus, disclosed that 4 out of 29 families (14%) would have considered an abortion if prenatal diagnosis had not been available. It was shown that prenatal diagnosis by amniocentesis not only offered a great relief of anxiety in the majority of the patients but also provided a mechanism for protecting a normal unborn offspring from being aborted in these genetically high-risk families.

In the past 16 years, prenatal diagnosis of genetic disorders by amniocentesis became available in many medical centers.[1] However, the data concerning its psychological effects on the patient are meager.[2] The purpose of this report is to present the initial experience of this procedure and the benefits afforded to the families who have utilized the services of the Cytogenetics Unit in the Department of Gynecology and Obstetrics at the Medical College of Wisconsin.

Material and method

Indications for amniocentesis for genetic diagnosis (genetic amniocentesis) include chromosome disorders, X-linked disorders, metabolic disorders, and open neural tube defects (Table 1).

The patients with these indications receive appropriate genetic counseling; and if they choose to undergo the procedure, they sign an Informed Consent Form. Prior to transabdominal amniocentesis, ultrasonography is performed to measure the biparietal diameter of the fetal head, to check for the presence or absence of multiple gestations, and to determine the location of the placenta. Then, the largest amniotic space without fetal parts or placenta is delineated for proper insertion of the needle. The fetal heart tones are checked before and after the amniocentesis. The specimens obtained by a completely sterile technic at around the 15th to 16th week of gestation are processed by the method described by Bassam, et al.[3]

A questionnaire was distributed to 31 families whose most recent pregnancy had been monitored by genetic amniocentesis. Both husband and wife were asked to respond to certain questions; for example, those relating to the level of concern over the pregnancy. Twenty-nine out of 31 families (94%) completed the questionnaire.

The indications for amniocentesis in this group of cases are included in Table 1. Most studies were performed on women in their second trimester of pregnancy, over the age of 35, who were referred for a Down's syndrome screening. Those with a prior history of a genetically abnormal child were the next most frequent request for cytogenetic study. Although the participants were asked a broad range of questions, only those responses to questions concerning attitudes towards their own pregnancies and towards the diagnostic procedures they underwent are reported here.

Results

The vast majority of patients found the procedure to be of great value (94%) and would repeat it in the case of a future pregnancy (83%). These families were very concerned about the outcome of the pregnancy. Fifty-five percent of them described themselves as moderately to severely worried. Ninety-three percent of the respondents felt that their anxiety about their pregnancy was relieved after receiving the test results.

Ninety-seven percent of the patients would have considered a termination of the pregnancy if the test results had showed the presence of an abnormal fetus. Four families would have considered an abortion if these tests had not been available to them. However, note that no abnormal fetuses were diagnosed among the respondents. Therefore, no abortions were done (Table 1).

There were 16 planned pregnancies in this study, and 14 of these women had had prior knowledge of amniocentesis. In these cases the availability of this service may have played a role in their decision to attempt another pregnancy.

When asked to compare their experience of amniocentesis to a venipuncture, the majority of women responded that any discomfort during the procedure was generally comparable to that of venipuncture,

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Table 1—Questionnaire respondents according to indication for amniocentesis

INDICATION FOR AMNIOCENTESIS	EMPIRICAL RISK OF AFFECTED FETUS*	NO. OF PATIENTS	TEST RESULT	RELIEF OF ANXIETY		WOULD HAVE CONSIDERED ABORTION IF PRENATAL DIAGNOSIS HAD NOT BEEN AVAILABLE		
				Yes	No	Yes	No	Undecided
Chromosome disorder								
Previous child w/chromosome abnormality	1.5%	9	Normal	9	0	2	7	0
Maternal age of 35 or over	2.3-3.8%	13	Normal	11†	0	1	11	1
Parental carrier of abnormal chromosomes	18.9%	2	Normal	2	0	0	2	0
Other	1.7%	1	Normal	1	0	0	1	0
X-linked disorders	45.3%‡	1	Normal	1	0	0	0	1
Metabolic disorders	20.0%	0	—	—	—	—	—	—
Open neural tube defects	8.8%	3	Normal	3	0	1	1	1
TOTAL		29		27	0	4	22	3

*From Golbus.[1]
†Two of the thirteen patients did not have anxiety prior to testing.
‡This figure is based primarily on the diagnosis of male sex.

although some indicated that it was less painful and some reported that it was a little more painful. There were no complications from this procedure.

Comment

A prospective study of the safety and accuracy of midtrimester amniocentesis consisting of 1,040 subjects and 992 controls was carried out by NICHD.[4] There was no statistically significant difference between the two groups in rate of fetal loss (3.5% for the subjects, 3.2% for the controls) or incidence of complications of pregnancy or delivery. Newborn examination indicated no significant differences between the two groups in incidence of congenital anomalies and no evidence of physical injury resulting from amniocentesis. The two groups did not differ significantly in physical, neurological or developmental status at one year of age. Diagnostic accuracy was 99.4%.

However, in their study immediate complications of amniocentesis (vaginal bleeding or amniotic fluid leakage) occurred in approximately 2% of the women. This type of complications can be minimized by using a smaller needle (we prefer a 22 gauge disposable spinal needle) and by defining the largest empty space of amniotic sac by a careful ultrasound scan immediately preceding amniocentesis.

In general, the rate of failures to obtain a result from chromosome studies was estimated to be above 2.5%.[1] During the first 25 months experience of our cytogenetic laboratory, 64 amniotic fluid samples have been screened for prenatal diagnosis. There have been no failures in culturing these delicate fetal cells, and only in one case was it deemed necessary to repeat an amniocentesis in order to clarify an ambiguous result. No complications have resulted from the amniocentesis among this group of patients. This success is in part due to the cooperation of referring physicians who directed their patients to our institution for performance of amniocentesis, thus minimizing the risk of the procedure such as puncturing the fetus or the placenta ("bloody tap"), and reducing the possibility of contamination of the specimen during its transportation. Owing to our excellent sonographers, Dr Bruce D Doust and Dr W Dennis Foley, we have had no bloody taps for the past two years.

Prenatal diagnosis offers a new source of information to both the obstetrician and the patient. If the fetus is normal, the parents are free to enjoy the remainder of the pregnancy without concern of a malformed infant. If the fetus is abnormal, the obstetrician has an important role in defining the potential severity of the fetal abnormality for the family and in assisting them in their difficult decision regarding the outcome of the pregnancy.

This preliminary study demonstrated the positive benefits of prenatal diagnosis by amniocentesis which offers a precise mechanism of protecting and preserving the normal fetus. During the past decade, increasing concern over the birth of a child with serious genetic defects has caused many patients to resort to an elective abortion without an accurate knowledge of genetic status of the fetus. As a result, pregnancies have been and are being terminated for *potential* genetic defects, where in reality the fetus is genetically normal.

In conclusion, the *accurate* cytogenetic study of fetal cells in the amniotic fluid can assure the family of a genetically normal fetus and protect the birth rights of the unborn fetus.

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Cerebral cysticercosis

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ALTHOUGH RARE in the United States, cerebral cysticercosis is one of the common causes of cerebral mass lesions in countries where the parasite is endemic. As most urban centers in this country harbor a substantial Mexican-American population, this disease should be seriously considered in the diagnosis of patients presenting with focal epilepsy, as illustrated by the following case.

Case report

This 20-year-old Mexican woman was admitted to Milwaukee County Medical Center with a recent seizure. Six months prior to admission she had moved to Milwaukee from Mexico City. Her health was excellent until the afternoon of admission when she noticed twitching in the fourth and fifth fingers of her right hand. This progressed to clonic movements of her right arm and a generalized convulsion. The seizure lasted about 5 minutes, and she was lethargic for 30 minutes. She denied any aura. There was no history of seizures or head trauma. A history of eating uncooked food could not be obtained, although the history was limited by a language barrier.

Her medical history was unremarkable, and there was no familial predisposition to seizures. When examined, two hours after her seizures, the patient seemed well. Her physical examination was unremarkable; specifically, neither weakness nor muscle tenderness was noted.

Her hemoglobin level was 12.4 gm per dl and the white blood cell count was 5100 per cu mm. Only one eosinophil was noted in the differential count. Electrolytes were normal, the VDRL was nonreactive, and the stool was guaiac positive. X-ray films of the chest were normal, but the skull roentgenograms demonstrated two small calcific densities in the left posterior parietal region (Fig 1). (The pineal gland was not calcified.) Electroencephalographic studies were normal. Cerebral computerized axial tomography was abnormal in that it disclosed calcific densities in the left parietal lobe and a surrounding area of decreased density. These findings were consistent with either dystrophic calcification and infarction, or a low grade tumor. There was no mass effect, and no enhancement was noted following infusion with iodinated dye (Conray®) (Fig 2).

Cerebral angiograms were normal. Radiologic and proctoscopic examinations of the gastrointestinal tract did not reveal a source for the fecal blood. Stool cultures were positive for Trichuris. Intradermal testing for mumps, tuberculosis coccidioides and histoplasmin were all negative. Serum hemagglutination inhibition titers for cysticercus were weakly reactive at a titer of 1:64. No antibody to histoplasmosis, coccidioides or blastomycosis could be detected in serum. A lumbar puncture yielded an opening pressure of 124 mm H_2O, with a protein of 26 mg per dl and glucose of 62 mg per dl. There were two lymphocytes per cu mm. Cultures of the spinal fluid were negative, as were hemagglutination inhibition titers for cysticercosis.

The patient was treated with phenytoin, and seizures have not recurred in the subsequent six months.

Discussion

Cerebral cysticercosis was first clearly described in 1650 by Paranolus in a man who died during a seizure.[1,2,3] In 1855, Kuchenmeister fed cysticerci to a condemned murderer and after death demonstrated several specimens of *Taenia solium* in the intestine, thereby concluding that cysticercus cellulosae was in fact the larval form of the pork tapeworm.[1]

Although rare in the United States, cysticercosis is endemic in Mexico, Poland, Chile, and

Figure 1—Lateral skull x-ray film of patient described in text, demonstrating the left parietal calcifications.

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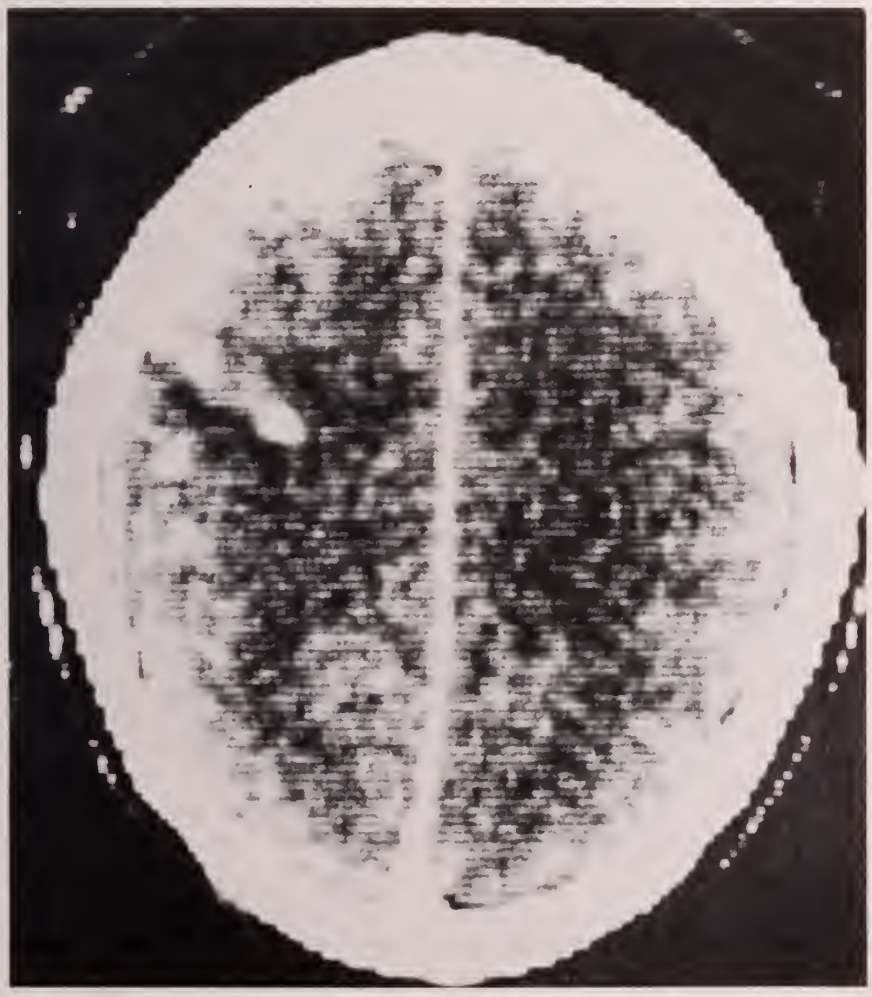
Spain.[1,4,5,6,7,8] Of 100 consecutive cases of expanding intracranial lesions from Mexico, 25 were cysts of *Taenia solium*. In Chile the incidence was reported to be about half this figure, while in Spain it amounted to about 2%.[1] In a postmortem study conducted at the General Hospital in Mexico City, there was a 3.6% incidence of cerebral cysticercosis over a consecutive six-year period. Furthermore, at the same institution, the disease accounted for 35% of the craniotomies performed over a one-year period.[9]

Understanding the parasite's invasiveness requires a knowledge of its life history. Typically man is the definitive host for the adult tapeworm, *Taenia solium*. Following ingestion of larvae by man, the adult tapeworm develops within the intestine; and eventually proglottids (or eggs) are discharged into the feces. The eggs can be ingested by the pig, where larvae develop, penetrate the intestinal wall, and encyst in muscle.[1,4,5,6,8,10]

Human infection occurs basically by three routes: (1) ingestion of insufficiently cooked pork containing encysted larvae, (2) ingestion of food contaminated by the hands of carriers, and (3) regurgitation of proglottids into the stomach (reverse peristalsis). When man ingests the eggs (proglottids), he becomes the intermediate host; and larvae are blood-borne to muscle, liver, eye, brain, or other organs.[1,4,5,8,10]

Figure 2—Appearance of left parietal calcification on computerized axial tomogram. An area of decreased density, probably edema, surrounds the calcification. This study was performed 24 hours after the patient's seizure.



The cysticerci often number into the thousands and may develop in any tissue or organ of the body. Upon implantation the growing cyst produces an inflammatory reaction that results in the production of a fibrous capsule. Upon the death of the larvae, as long as five years after tissue invasion, the degenerating parasite usually undergoes calcification. The subsequent symptoms produced depend upon the tissue invaded and the number of cysticerci present.[10]

During the early invasive stages, the patient may be asymptomatic or may complain of slight mvalgia or mild fever. Muscular and subcutaneous infection is usually well tolerated, and even heavy infections may cause no symptoms. Weakness, fatigue, cramps, and weight loss may be present.[10]

The serious manifestations of the disease occur in cerebral cysticercosis, in which the organisms invade the brain or meninges. Inflammation and encapsulation occur, and the neuroglia and nerves can show pressure or toxic changes. Subsequently the cyst undergoes calcification.[10]

Definite neurologic symptoms may not occur for up to five or more years after the acute infection.[10] Symptoms can be classified into three major syndromes. Single cysts can produce a mass, and subsequent symptoms are suggestive of a cerebral neoplasm. The cyst can produce seizures, hemiparesis, or focal cerebral deficits. Seizures occur in 40 to 90 percent of patients, and the majority of these patients have focal seizures.[4,11,12] Obstructive hydrocephalus is seen when the cysts are located within a ventricle or adjacent to the aqueduct.[1,2,5] Certain cases demonstrating a single symptomatic cyst may be amenable to neurosurgical intervention.[1,4,6,7]

The second classification of symptoms are those secondary to diffuse intracranial infestation and increased pressure. Symptoms are nonfocal and consist of headache, nausea, vomiting, papilledema, and mental changes. Surgery has little

to offer, although cranial decompression may be palliative.[1,4,6,7]

The third category of patients are those afflicted by a proliferative inflammatory reaction in the meninges. The symptoms are those of a chronic meningitis. Increased intracranial pressure occurs as a sequal to the meningitis.[1,4,6,7]

Typically, there are no pathognomonic features, and physical examination may or may not reveal a focal deficit. Therefore, the diagnosis is frequently based on laboratory findings. Knowledge of the epidemiology of the disease is of paramount importance. Cysticercosis should be seriously considered when evaluating patients from a country where the disease is endemic. Additional evidence may be gained by finding eosinophilia in the peripheral blood. The cerebrospinal fluid may be under increased pressure and contain an excessive amount of globulin, lymphocytes, and/or eosinophils.[1,4,5] Examination of the stool for ova and parasites is of limited value, since approximately only 20 percent of patients harbor a concomitant *Taenia solium* intestinal infection.[2,4]

Cerebrospinal fluid complement fixation tests for *Taenia solium* are diagnostic of active infection if strongly positive; *ie,* greater than a 1:16 titer. A negative test does not preclude the diagnosis, since the test is reportedly positive in only 60 to 80 percent of the patients.[1,5] Furthermore, spinal fluid titers tend to return to normal after the death of the organism.[5] The hemagglutination inhibition test performed on the serum is diagnostic of active infection if the titer is 1:128 or greater.[13] Lower titer, as was the case with our patient, is consistent with old antecedent infection or exposure. As with the spinal fluid serology, a negative result does not rule out infection.[5]

Skull x-ray films are of value if they demonstrate multiple small areas of the characteristic "shot gun" calcifications within the cysts. These densities are only present in 11 to 33 percent of the cases.[1,4,5] Radiologic signs of increased intracranial pressure have been noted in up to 72 percent of patients.[5]

Radionuclide brain scans can demonstrate areas of increased uptake due to the inflammation produced by the cysts. Angiography, pneumoencephalography, or computerized axial tomography may disclose the presence of avascular cystic masses within the brain, and may indicate the presence of obstructive hydrocephalus. Finally, soft tissue films of the extremities may show multiple calcified cysts adjacent to the long bones or within the muscles.[1,4,5,10,11]

Most authors conclude that treatment of the symptomatic patient is limited at its best. Seizures, if present, should be treated medically, and patients usually remain asymptomatic if epilepsy is the only manifestation of their illness. Focal symptoms or ventricular obstruction caused by an isolated cyst may be amenable to appropriate neurosurgical intervention. Surgical excision is neither more difficult nor more dangerous than for the average brain tumor. In those patients with widespread disease, intracranial therapy should be directed at the reduction of intracranial pressure.[1,2,4,5,6,7,9]

Summary

The diagnosis of cerebral cysticercosis was made in a 20-year-old Mexican woman with a Jacksonian seizure, who had lived in an endemic area, and demonstrated characteristic intracranial calcifications, and elevated antibody titers. In view of the fact that increasing numbers of Mexican-Americans are residing in northern urban areas, it is important that this condition be considered in the evaluation of Mexican-Americans presenting with focal neurologic symptoms.

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ABSTRACT/ WISCONSIN AUTHOR

Prediction of therapeutic response in acute leukemia

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In 26 patients with acute leukemia the degree of suppression of tritiated thymidine incorporation into leukemic cells in short-term culture by chemotherapeutic agents was studied by *in vitro* methods. The strongest correlation with the subsequent achievement of remission in the patient was observed with cytosine arabinoside (Ara-C). Six of 7 patients with acute myelocytic and myelomonocytic leukemia whose cells demonstrated *in vitro* suppression of ^{3}H-thymidine incorporation by Ara-C to 15% or less of control counts subsequently achieved remission, while 4 to 6 patients whose cells showed lesser inhibition did not achieve remission. Patients with acute lymphocytic leukemia showed a similar pattern. These results indicate that a group of patients with a high expectation of remission with standard regimens can be delineated with such studies. In others, more aggressive and less conventional chemotherapy may be indicated. ■

The impact of perinatal intensive care and regionalization in Wisconsin

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OVER THE PAST DECADE Wisconsin has moved ahead of other states in regionalization of perinatal care. The article selected for this issue of Perinatology clearly identifies a dramatic result of our regionalization effort. It is hoped that with increasing awareness of the definite benefits to be obtained through regionalization practicing health personnel will support the concept and work within its frame work.

During the years 1967 and 1968 Wisconsin began regionalization of maternal and neonatal care. After an initial comprehensive review of community health care providers and state demographics, five "activity" areas were identified and pursued in response to specific recognized needs. The activity areas included: (1) educational programs for community hospitals, (2) consultation programs, (3) communication and team development programs, (4) Regional Center development, and (5) stimulation of support by other state agencies and groups.

Accurately judging the success of the Wisconsin Perinatal Care Program would require an extensive, multifaceted approach. However, an indication can be obtained by comparing present state neonatal mortality rates with those prior to regionalization and with national statistics. Since the leading contributor to neonatal mortality is Hyaline Membrane Disease/Respiratory Distress Syndrome (HMD/RDS), comparison of state and national norms for neonatal death rates associated with the disease also provides an index to the impact of regionalized neonatal care. This report presents our review of that data.

In a computer-based analysis of United States mortality records between 1968 and 1974, Manniello and Farrell[1] noted a 10 percent decline in the number of live births and a fall in the annual newborn mortality rate from 16.1 to 12.3 per 1000 live births. The mortality rate declined approximately 25 percent for both white and black infants dying before 28 days of age. Specific causalities of death exhibited changing patterns over the seven years. Asphyxia was replaced by HMD/RDS as the primary etiology after 1970.

Since the first description of Hyaline Membrane Disease 25 years ago, the disease has become widely appreciated as a leading cause of infant mortality. Until recently, however, no statistics were available on a nationwide basis, and estimates of national mortality showed a wide range from 12,000 to 40,000 cases per year. Farrell and Wood[2] have analyzed the data on deaths associated with HMD/RDS collected by the National Center for Health Statistics between 1968 and 1974. Their findings indicate that HMD/RDS accounted for an increasing number of neonatal deaths during the survey period with an average contribution of 20 percent to overall neonatal mortality (9010 deaths per year). Fatalities tended to cluster in the summer months and were relatively fewer in mid-winter. Over 90 percent of fatal outcomes were determined by the fourth day of life and nearly 50 percent occurred during the 24 hours after birth.

Individual states showed a marked variation in mortality rates due to HMD/RDS, but these generally agreed with overall neonatal mortality rates. In supporting the concept of regional perinatal care, the authors suggested that the variability was consistent with a need for more uniform geographical distribution of advanced respiratory care techniques.

When considered individually, it was evident that some states did not share the increasing mortality rates due to HMD/RDS. Wisconsin was particularly noted since it alone began the survey period with a relatively low rate and subsequently reduced the figure to one of the lowest observed.

During the four years prior to regionalization within Wisconsin, the neonatal mortality rate averaged 16.1 deaths per 1000 live births. Subsequently, the rate has been well below the national average and has declined yearly, reaching 9.7 deaths per 1000 live births in 1975. This impressive trend is shown in the accompanying figure.

As mentioned previously, HMD/RDS as a cause of death increased nationally through 1972 and remains the major contributor to neonatal mortality. Wisconsin neonatal mortality rates due to HMD/RDS have consistently been 25 to 44 percent below national norms. Further, in spite of increasing national trends, the Wisconsin HMD/

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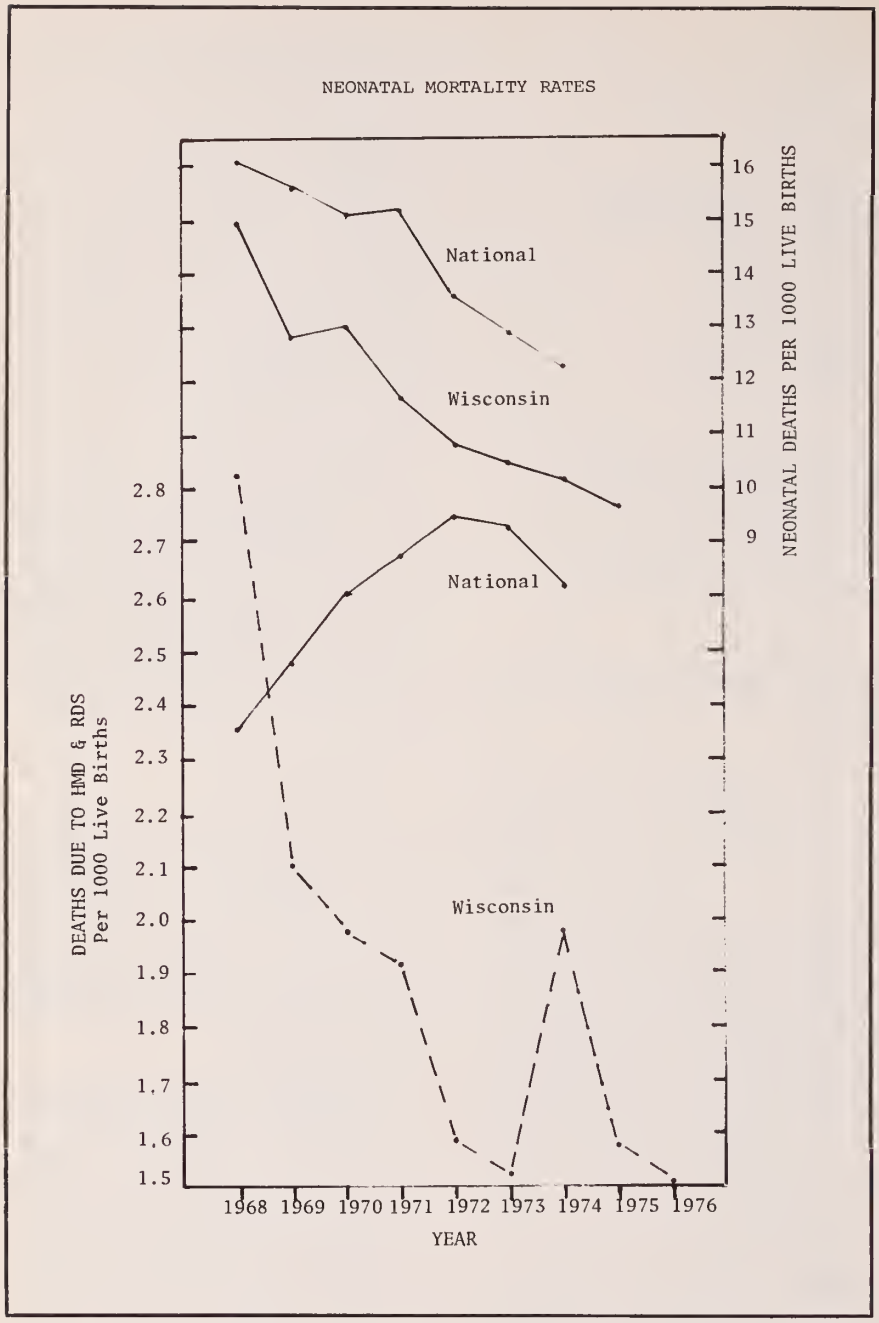

RDS mortality rate has (except for 1974) shown a yearly decline. The implementation and maintenance of the Wisconsin Perinatal Care Program has evolved through a cooperative relationship among state educational institutions, the Division of Health, private health professionals, and the consumer. Hopefully, with continued efforts directed toward perinatal care, we will maintain and perhaps surpass this fine record.

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ABSTRACTS/ WISCONSIN AUTHORS

Hemorrhagic peripapillary lesions in presumed ocular histoplasmosis

TRAVIS A MEREDITH, MD and THOMAS M AABERG, MD, Medical College of Wisconsin, Milwaukee, Wis: *Am J Ophthal* 84:160-169 (Aug) 1977

In the presumed ocular histoplasmosis syndrome, hemorrhagic lesions generally occur directly within the macula. Bleeding may also originate from atrophic peripapillary lesions, however. Eight eyes in five patients with hemorrhagic peripapillary histoplasmosis were studied and found to demonstrate prolonged symptomatic episodes with recurrent bleeding subretinally from their lesions. In five of the eight eyes, final visual acuity was equal to or better than 20/40. The growth of subretinal neovascular membranes could be demonstrated at the margins of the atrophic scars on fluorescein angiography. In the late stages, retinal pigment epithelium was lost over areas where blood and subretinal fluid had been in contact with it and a white subretinal mass developed in the region where the abnormal vessels had been present. Argon laser photocoagulation was used successfully to destroy the neovascular tissue in two cases, but caused a permanent arcuate scotoma in one case. ■

Plasma erythropoietin levels in patients on chronic hemodialysis

PETER C RAICH, MD and DONALD R KORST, MD, Madison: *Arch Pathol Lab Med* 102:73-75 (Feb) 1978

The anemia of chronic renal disease has been attributed primarily to a decrease in erythropoietin production. This study demonstrates that measurable levels of plasma erythropoietin can be detected in a majority of patients with end-stage renal failure on chronic hemodialysis. These levels were not related to the type of renal disease; nor were they significantly affected by androgenic therapy or by nephrectomy. Although erythropoietin elevations in such patients were somewhat less than in non-uremic patients with comparable anemia, the presence of measurable erythropoietin levels suggests that impaired marrow response may play a role in the anemia of chronic renal failure. ■

Urinary cytology as a screening study to detect urinary malignancies

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• A population of 1,337 people, age 50 to 65 years, was screened by cytologic examination of voided urine. Thirteen of these urines varied in abnormality from slight atypia to frank tumor cells. All were evaluated and one ureteral neoplasm was identified. The study was disappointing in several respects.

THE GREATER MARSHFIELD Community Health Plan (GMCHP) is a closed-panel, prepaid, health-care program in Central Wisconsin with a current enrollment of approximately 40,000 patients. This group of patients lends itself well to various types of case-finding studies because of several factors including easy identification of categories of patients due to computerized records, relative proximity of patients to their health-care providers, and the ability to fund relatively inexpensive studies such as this without cost to the patient.

This type of population was felt to be an ideal one for a study of urinary sediment via cytologic examination to look for malignant cells arising from the urinary tract. The usefulness of urinary cytology in the identification of these lesions has been well documented.[1,2,3,4] It is recognized that the percentage of positive examinations will increase if specimens obtained by bladder washing are used instead of simple voided specimens.[5] Logistically, this approach was judged as not feasible for this study.

A computer search of all enrollees selected all males and females between the ages of 50 and 65 years. Patients older than 65 are not enrolled in the GMCHP. This search identified 5,342 persons in that age category. Each of these persons was then mailed a letter explaining the purpose of the study to identify unsuspected tumors of the urinary tract. Accompanying the explanatory letter was a card which became the only record of the encounter unless an abnormality in the cytologic examination was noted. Patients were instructed to present this card at the Marshfield Clinic anytime from 7:30 AM to 5:30 PM Monday through Friday.

The study began on November 17, 1976 and, at a rate of 400 per week, mailings were all completed by March 25, 1977. Of the 5,342 notified, only 1,337 responded, a disappointing rate of only 25% which cannot be explained. Undoubtedly, part of the reason was travel distance involved for some of the patients.

Of the 1,337 urines examined, 13 contained abnormal cells which varied from rare, mildly atypical cells in 11 of the 13 urines to 2 urines which showed markedly atypical cells strongly suggesting carcinoma.

All 13 of the subjects with abnormal urine, regardless of degree of abnormality, were called in for intravenous pyelography and cystoscopy. One of the 13 (one of the two which showed frank tumor cells) presented at the emergency room before her appointment time with pain in the flank, and an intravenous pyelogram disclosed a ureteral tumor. In addition, a cervical lymph node was positive for transitional cell carcinoma. The other 12 had negative studies which, in some cases, included biopsy of the bladder and almost always included a repeat cytologic examination which was negative in all tested. The second patient who had tumor cells had a negative result, but follow-up evaluations will be continued indefinitely.

The cost of this study including printing costs, data processing, postage, special specimen cups, and secretarial time was approximately $1000 not including the cost of the x-rays or cystoscopic examinations done on the 13 "abnormals." These latter costs were absorbed by the Greater Marshfield Community Health Plan. Also not included is the normal charge for each of the cytologic examinations were they to be done for a purpose other than the screening study. This charge would have approximated $23,000, but the actual cost of this service was not estimated.

This study was disappointing in the low response rate and in the relatively small number of lesions detected. However, it was an inexpensive method of screening a pop-

From the Marshfield Clinic, Marshfield, Wisconsin
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ulation. A disturbing question which cannot yet be answered concerns the possibility of false negatives. The study will continue in an effort to answer this question by screening the computer rolls every three months for the next five years for a diagnosis of a urinary tract malignancy in any one of the studied population.

ACKNOWLEDGMENT: The author acknowledges with thanks the cooperation and considerable efforts of the cytotechnologists and Director of Laboratories, Joint Venture Laboratory, Marshfield Clinic and St Joseph's Hospital.

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ABSTRACT/ WISCONSIN AUTHORS

Diphenylhydantoin effects on thyroid function tests

ROBERT H CAPLAN, MD; ROBERT MORDON, BS; KAREN KRISTOFF, BS; and GARY WICKUS, PhD; Gundersen Clinic Ltd and LaCrosse Lutheran Hospital, LaCrosse, Wis: *Ann Neurology* 1:603-604 (June) 1977

We measured serum thyroxine as thyroxine iodine (T_4I), triiodothyronine resin uptake (T_3U), free thyroxine index (FTI), and free thyroxine equivalent (FTE) in 31 euthyroid patients treated with diphenylhydantoin (DPH) and in 105 euthyroid control subjects. The T_4I was reduced by 30%, the FTI and FTE were reduced by 25%, and the T_3U was slightly increased in the DPH-treated patients. We conclude that these tests are not accurate estimates of thyroid function in patients treated with DPH if the usual range is utilized for interpretation. ■

Stamping out the rainbow

Towards the rational use of regular insulin in juvenile diabetes mellitus

Elaine Kohler, MD, Milwaukee, Wisconsin

THE SO-CALLED "rainbow" or sliding scale method of treating diabetes is basically irrational, but it continues to be used. The term rainbow is said to derive from the different colors which Benedict's solution turns with varying amounts of sugar in the urine. It has, however, been suggested that the name "rainbow" reflects the fact that it is designed so that one can never reach the end. It is most often used within the hospital where more accurate means of measuring sugar are available. In that circumstance it is clearly an anachronism harking back to the era when Benedict's was the only available method of measuring sugar.

The "rainbow" is often ordered as "regular insulin q 4 h according to urine sugars; negative −0, 1+ −5 units; 2+ −10 units; 3+ −15 units; 4+ −20 units." Additional insulin is frequently added for the presence of acetone. Physicians with a prime interest in diabetes have, for the most part, given it up as its use has been criticized in the literature.[1,2,3] Nonetheless, it persists because it offers a system which relieves the physician of making repeated decisions. The following is an attempt to stamp out the rainbow as a method of managing diabetes with regular insulin by pointing out the various misconceptions upon which it is based.

The colors of the rainbow

When urine sugar results are reported in percents, physicians frequently ask what percent means. Percent clearly means how many grams of glucose are present in 100 ml of urine. The question is what pluses mean. Actually the plus-system is derived from change and intensity of color caused by the percent of glucose in urine. Unfortunately, the same plus-levels reflect different amounts of urine sugar in different testing methods (Fig 1). For example, the amount of glucose which reads 3+ by Testape reads 1+ by Clinitest.[4] That is the first problem of the rainbow.

The dilution factor

The question is then asked, whether a similar "rainbow" based on percentages could be used. While this would be more meaningful, the dilution factor remains. One gram of glucose excreted can be read as anything from 1/4% to 5% depending on the amount of urine in which it is excreted (Fig 2).

If the extent of glucose excretion is to be used, it would be more informative to use total grams of glucose excreted. In a hospital setting, this can be measured in the laboratory if frozen to prevent glycolysis. For more immediate results, a semiquantitative measurement can be obtained at the bedside by measuring the volume of urine and multiplying it times the percent of glucose by the most quantitative bedside method, 2-drop Clinitest.[5,6,7,8]

Chasing the "rainbow"— the timing of insulin

As initially stated, the "rainbow" method is not designed to allow one to achieve normal sugars. Perhaps the most dangerous rainbow schedule is every four hours around the clock without relationship to caloric intake. If the patient is eating three

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or four meals during the day and nothing through the night, this regimen can very easily result in nighttime hypoglycemia. During the day when meals are generally about four hours apart, one will be "chasing the rainbow" because every time the urine sugar normalizes and a negative reading is seen, no insulin will be given and the meal which follows will lead to hyperglycemia. The real danger, however, comes when negative readings occur before the last meal or snack of the day. The individual will get no insulin, eat a meal and four hours later, the sugar will be high. The patient will then be given a maximum insulin dose, but nothing to eat, which can easily lead to nocturnal hypoglycemia (Fig 3).

Alternatively, the rainbow is occasionally written for every six hours. Although this better approximates the duration of regular insulin, it is unphysiologic because meals are not normally six hours apart and people usually sleep more than six hours at a time. Thus, either the insulin has no relation whatsoever to oral intake or the patient is on an unrealistic regimen, which involves eating every six hours.

In order to avoid both difficulties, the rainbow is sometimes limited to before meals and the bedtime snack. While this is safer because it avoids nocturnal hypoglycemia, one will still never reach the "end of the rainbow" because when the sugar normalizes, no insulin is given until hyperglycemia recurs.

What is the alternative?

Methods for bringing down very high sugars of patients in ketoacidosis have been described for adults and children.[9,10] For the ambulatory patient not in need of intravenous therapy, beginning with a low dose of regular insulin before a meal then adjusting the dose taking into account caloric intake and postprandial blood sugar can provide a rational assessment of insulin needs. The maintainance regimen to be used at home can be begun after a few such doses and "fine tuning" accomplished with that regimen.

The rainbow is also frequently used in or out of the hospital for a patient whose intake is interrupted by vomiting or other illness. For these circumstances we divide the patient's usual daily dose into four, call that the "basic dose" of regular insulin, and adjust it according to intake increasing only for significant increases in urine sugar and ketones (Fig 4).

SUMMARY:
The trouble with the rainbow

In summary, basing insulin dose on the plus system of urine sugars is irrational because intermediate readings vary according to testing methods used and the dilution of sugar in urine. Giving insulin based on prior sugar spill every four hours throughout a 24-hour period is dangerous because of the lack of intake at night. Giving insulin every six hours is unphysiologic. Giving insulin before meals and the bedtime snack is more rational but the "rainbow" system is designed to ensure intermittent hyperglycemia.

The published methods of intravenous insulin administration are effective for the very ill patient. A few doses of regular insulin adjusted according to intake and consequent blood sugar followed by institution of the maintenance regimen is a more direct way of administering appropriate insulin.

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Glucose Grams %	0	1/20	1/10	1/4	1/2	3/4	1	2	3	5
Clinitest 2-drop	Neg			Tr	1/2%		1%	2%	3%	5%
Clinitest 5-drop	Neg			Tr	+	++	+++	++++		
Diastix	Neg		Tr	+	++		+++	++++		
TesTape	Neg		+	++	+++			++++		
Clinistix	Neg		Small	Medium		Large				
Chemstrip	Neg	+		++			+++			
Benedict's	Neg			+			++		+++	++++

Figure 1—What does the plus system mean?

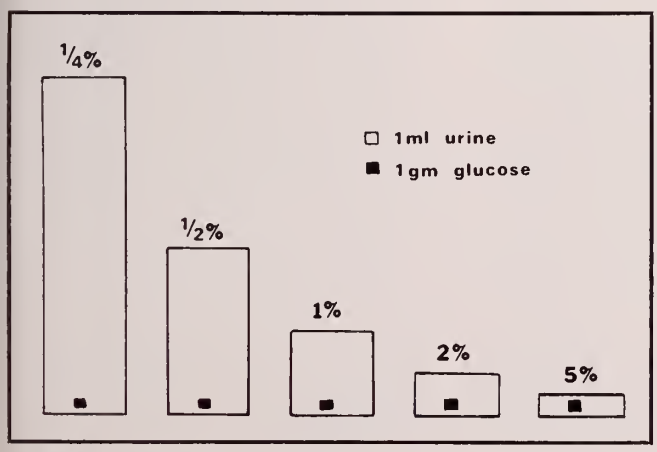

Figure 2—The dilution factor.

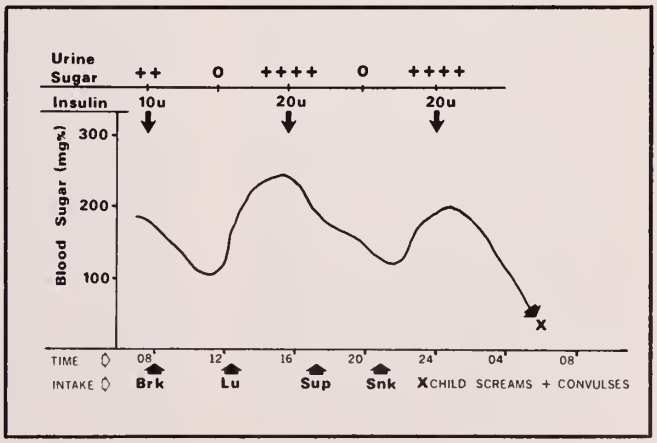

Figure 3—Rainbow insulin every four hours.

REGULAR INSULIN
Before meals and
bedtime snack:

	INTAKE	URINE TEST
2 × Basic dose = (Total daily dose / 2)	Eating normally	5%/Mod-Lg*
1½ × Basic dose = (Total daily dose / 3)	Eating normally Eating poorly	> Usual range 5%/Mod-Lg*
Basic dose = (Total daily dose / 4)	Eating normally Eating poorly Not eating	Usual range > Usual range 5%/Mod-Lg*
Basic dose = (Total daily dose / 8)	Eating poorly Not eating	Usual range > Usual range
No insulin	Not eating	Usual range

(*Call MD if 5%/Lg more than once!)

Figure 4—A schedule for use of regular insulin.

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ABSTRACTS/ WISCONSIN AUTHORS

Respiratory abnormalities among grain handlers —a clinical, physiologic, and immunologic study

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Exposure to grain dust induced eye, nasal, and respiratory symptoms in most of 300 grain handlers studied. Most symptoms on exposure were independent of age, length of employment, smoking history, and presence of precipitins to grain or fungal antigens. Overall, the prevalence of symptoms and of abnormal ventilatory functions was higher among cutaneous reactors to grain, grain dust, or common allergens. In addition to the acute airways effects it is highly probable that grain dust contributes to and, in some instances, causes chronic airways disease. History of grain fever was present in 19%, but definite episodes of hypersensitivity pneumonitis could not be established with certainty. There was no radiological evidence of chronic interstitial pneumonitis in this population. ■

Flat warts undergoing involution

ALEXANDER BERMAN, MD and RICHARD K WINKELMANN, MD, Milwaukee, Wis: *Arch Dermatol* 113: 1219-1221 (Sept) 1977

Patients with multiple flat warts were observed during the period of involution shortly before regression of the warts. Clinical findings that seemed to suggest onset of the involutionary process included: development of erythema and edema at the base of the warts, onset of itching of the warts, instability of the lesions, regression of one or more lesions, development of depigmented halos around the flat warts, and an efflorescence of tiny new warts.

Flat warts excised during the period of involution were characterized histopathologically by mononuclear cell infiltration around subpapillary blood vessels, exocytosis of mononuclear cells into the epidermis, and a spectrum of degenerative epidermal changes that culminated in focal areas of necrosis within the epidermis. Lesions near the end stage of involution did not show the histopathologic features of flat warts and were not recognizable histologically as flat warts.

In one patient with multiple flat warts, 5 lesions were excised when the onset of involution was suspected clinically. Microscopic study demonstrated involutionary changes in 3 of the specimens; involution could not be suspected in 2 specimens. Involutionary changes in flat warts apparently do not develop at the same rate in all lesions but proceed independently in individual warts. Involution evolves over a period of several weeks: 2 weeks was the shortest period observed, 10 weeks the longest.

The mononuclear cell-associated injury to the epidermis resembles that seen in delayed cutaneous hypersensitivity responses and suggests that regression of flat warts may be due to a cell-mediated rejection reaction. ■

Biofeedback training in the physician's office: transfer of pain clinic advances to primary care

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PAIN PERSISTING months or years beyond primary treatment has attracted considerable attention during the past 50 years. Indeed, since the introduction of cordotomy an increasing variety of approaches has been added to the historical attack upon pain, and there have been more innovations in the past decade than at any similar period in recorded history. Although relatively little of this abundant progress has filtered into general medical practice, the most important modalities—external electrical stimulation and Biogenics™—are potentially applicable to almost every physician's practice. This report will summarize the current pain clinic boom[1] and suggest practical application of the two most potent therapeutic processes to the office of primary physicians.

Traditional Pain Clinics: "Multidisciplinary" in nature, patients are primarily subjected to a wide variety of diagnostic tests. Nerve blocks, x-ray studies, and review by a number of specialists are the major consideration. Once diagnosis is made, treatment is largely with drugs, surgery, or psychotherapy. Such clinics tend to perpetuate the belief that pain is "either" physical or emotional. Unfortunately, the major destructive procedures (lobotomy, rhizotomy, cordotomy) are really applicable only to cancer pain, rarely give lasting pain relief, and are accompanied by an unacceptably high rate of complications. With rare exception drugs offer only increasing habituation and often cause depression and other personality alterations. The traditional psychotherapeutic approach has not solved the problem for most pain patients. These traditional clinics have not significantly helped the overall pain control situation.

Behavioral Modification: Recognizing that pain behavior is a learned response, Fordyce instituted the first major psychological improvement in therapy of pain.[2] Using the simple and effective technique of ignoring pain behavior and rewarding more acceptable behavior (with encouragement and smiles), combined with drug withdrawal, Fordyce developed a model that has served most innovators of the past decade. His program initially consisted of eight weeks in the hospital, but this has been shortened to one month.

Comprehensive Pain Clinics: In 1971 The Pain Rehabilitation Center® added electrical stimulation and related techniques to behavioral modification.[3,4] Since then a number of new pain control clinics have evolved. These range from 12-day outpatient programs costing about $1,600 to two or three months hospital-based programs costing up to $10,000 or $12,000. Varying markedly in basic approach, these clinics nevertheless incorporate some common techniques:

1. Withdrawal of drugs, except possibly antidepressants (even then aim for withdrawal);
2. Increasing physical activity, passive and active;
3. Psychophysiologic balancing to establish a more satisfying life script through one or more of these:
   a. behavioral modification,
   b. psychological counseling,
   c. hypnosis,
   d. Biogenics™ (biofeedback, autogenic training, deep relaxation, and related voluntary self-regulation techniques);
4. Use of TENS (transcutaneous electrical nerve stimulation);[5,6,7,8]
5. Return to work if possible but not until patient is truly emotionally and physically rehabilitated.

Acupuncture, ice packs, massage and facet rhizotomy (denervation of spinal facet joints)[9,10,11] have been used at some centers.

Patient population

About 60% of patients frequenting pain clinics have back problems; most often these patients have had several unsuccessful back operations. Worker's Compensation injuries account for 15% to 80% of patients treated at these clinics. Headaches represent another large group of patients and the remainder suffer from the wide variety of painful illnesses—arthritis, post-herpetic pain, phantom limb pain, cancer, and the like.

Results

Almost all patients seen at various pain clinics have long, involved histories and represent continuing failures of standard therapy. The average patient has had pain well over two years (six plus years at our clinic). Thus, any "success" is a bonus for society. The great problem is the language of pain. Since pain is a subjective phenomenon, it is impossible to measure results. The following profile is suggested as a standard to allow comparisons among clinics.

From The Pain and Health Rehabilitation Center, SC.
Reprint requests to: C Norman Shealy, MD, The Pain and Health Rehabilitation Center™, SC, LaCrosse, Wis 54601.
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Unfortunately, at a recent symposium on "Pain Clinics—Techniques and Results" most participants did not report their overall results.[12] However, experience at The Pain and Health Rehabilitation Center,™ La Crosse, emphasizes the potential results. Using the Pain Profile[13] which assesses on scales of 0 to 100:

Severity of Pain
Physical Activity
% of Time Pain Present
Effect of Pain Upon Mood
Drug Consumption

Seventy-two percent of patients followed one year or more have improved 50 to 100%. Actually 90% had improved initially but 18% of patients failed to comply over the long run.

Of all patients who continued to practice Biogenics™ mental exercises, 84% were successful.

Of the therapeutic techniques which are determinable, the following are most important, in decreasing order:

1. Drug withdrawal — patients cannot practice mental training without a clear mind.
2. Biogenics™ (see below).
3. Physical exercise — both limbering and strengthening.
4. Facet rhizotomy.
5. Transcutaneous electrical nerve stimulation.

Implications

A. Since drug withdrawal is so important in treating chronic pain patients, it seems likely that initial caution in dispensing drugs would be worthwhile. As a general rule:

1. Avoid "prn" pain medications. Dispense drugs on a straight time contingency; *ie,* every 4 hours, and the like.
2. Avoid narcotics beyond four weeks.
3. Avoid the use of synthetic pain relievers other than aspirin and acetominophen. There is no proof that propoxyphene napsylate (Darvon®) and pentazocine hydrochloride (Talwin®) are superior to aspirin and acetaminophen and both these (Darvon® and Talwin®) are strongly habituating, lead to serious withdrawal symptoms (including DTs), confuse the patients, alter personality, and the like.
4. Avoid tranquilizers. These, especially diazepam (Valium®), lead to depression and other significant personality changes.
5. Consider antidepressants, especially tricyclics, such as amitriptyline HCl (Elavil®) and protriptyline HCl (Vivactil®).
6. Consider anticonvulsants—phenytoin sodium (Dilantin®) and Elavil® are helpful to patients who have sensory deprivation pain.

B. Early in the course of persisting pain, obtain an MMPI (Minnesota Multiphasic Personality Inventory).[14] If there are any abnormalities, be particularly on guard for psychological factors.

C. Consider the use of external electrical stimulation early in treatment of pain.[4] Eighty percent of patients with acute pain benefit from it. Combined with Therapac® ice packs most chronic pain might be prevented if effective somatophysiologic therapy is instituted early. Fifty percent of chronic pain patients achieve 50 to 100% pain relief with TENS. Details of the use of TENS have been published[6,7] so will not be repeated here. However, TENS is quite applicable to the average physician's office as detailed in the papers cited.[6,7]

D. Insure early progressive physical exercise, both limbering and strengthening.[15]

E. In patients with back and/or sciatic pain as well as neck pain, avoid "disc" surgery unless there is an unequivocal rupture. Consider facet rhizotomy before disc surgery.[10] Particularly avoid repeated surgical procedures. There is no evidence that second, third, or tentl laminectomies are more likely to b successful than first ones. Avoi fusions unless there is a real disloca tion. In patients with other types o pain, **stop** operating once the initia operation fails to relieve pain.

F. When primary treatment i not adequate, provide a good cours in Biogenics™. Biogenics™ i a system of biofeedback, autogenic training, and related exercises designed to help patients voluntarily achieve self-regulation of physiology and emotions. Although not available in every city, groups of several physicians could easily set up a Biogenics™ program which would be applicable not only to pain patients but also to most psychosomatic problems.

In addition, biofeedback training (BFT) can easily be adapted to use in the average physician's office. A wide variety of BFT devices are available for measuring EEG, EMG, GSR (galvanic skin resistance, a reflection of emotional stress), and temperature (reflecting local circulation). Although specific BFT training may be helpful in patients with focal muscle tension (EMG training helps especially in torticollis, for instance), or in cardiac arrhythmia (pulse trainers), most BFT is simply a tool to convince patients that their bodies respond to appropriate mental suggestions. *Relaxation alone* is capable of helping a majority of patients with a wide variety of stress-related illnesses. Insulin requirement is reduced and the biochemical stress reaction is shifted toward *The Relaxation Response* homeostasis.

Using the simple instructions in relaxation which can be taught by an office nurse, patients can learn basic biofeedback and relaxation skills with a minimum of physician time. Cassette tapes of basic Biogenics™ exercises for use at home can supplement office instructions. With the encouragement of physicians, most patients with psychophysiologic stress reactions can be successfully treated by these techniques.

Experiential workshops in Biogenics™ have been given to over 1,000 health professionals, many of whom have instituted successful therapy programs teaching Biogenics™ in the office setting.

Summary

In the past five years the establishment of comprehensive pain treatment centers has demonstrated that even severe, chronic pain can be greatly helped. It is also possible that some of the most difficult pain problems might be prevented by careful withholding of narcotics, synthetic pain relievers, tranquilizers and questionably indicated surgery. Early treatment with transcutaneous external nerve stimulation (TENS), ice, physical exercises, facet rhizotomy, biofeedback training (BFT), and Biogenics™ might help greatly. Incorporation of these techniques into the average physician's practice, especially the use of TENS and Biogenics™, offers an excellent opportunity for physicians to improve results in treating a wide variety of psychosomatic or stress diseases. Early referrals to comprehensive pain treatment clinics, by six months, is also potentially valuable when primary treatment fails.

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Fatal polymicrobial meningitis in a patient with epidermoid carcinoma complicating acne conglobata

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BACTERIAL MENINGITIS due to multiple organisms is a rare entity, and most reported cases were in patients having had underlying neurologic procedures.[1] This report concerns itself with a fatal polymicrobial meningitis terminating a chronic skin disease (acne conglobata) complicated by the development of epidermoid carcinoma.

Case report

A 61-year-old male had acne conglobata since age eighteen. In June 1975, biopsy of a chronically infected right lower neck ulcer revealed moderately well-differentiated squamous cell carcinoma. This was treated by incomplete excision, a skin flap and irradiation totalling 7,000 rads. Admission to the hospital in January 1976 was for revision of the deltopectoral flap.

Physical examination on admission revealed a chronically ill patient with extensive acne conglobata of the face, neck, back, and arms. There was draining ulceration at the right posterior base of the neck (Fig 1). Radiation hyperpigmentation over the neck also was present. There were bilateral crackling rales of the chest.

Admission laboratory data included a hematocrit reading of 36%; hemoglobin level, 11.3%; white blood cell count, 11,800/cu mm; glucose, 201 mg/100 ml and albumin 3.4 gm/100 ml. Serum calcium, phosphate, blood urea nitrogen, uric acid, cholesterol, total serum protein, total bilirubin, alkaline phosphatase, lactic dehydrogenase, serum glutamic oxaloacetic transaminase, and serum glutamic pyruvic transaminase were normal. Chest roentgenogram was normal and the electrocardiogram was consistent with an old inferior wall myocardial infarction.

On the second hospital day, insertion of the right deltopectoral flap was performed. A few hours later fever, altered mental status, and meningismus were noted. A lumbar puncture was done, and the cerebrospinal fluid was consistent with bacterial meningitis. Cultures from the right neck lesion originally isolated *Pseudomonas aeruginosa*, *Proteus mirabilis*, enterococcus, and several species of *Bacteroides* including *B. fragilis*. Cultures from the cerebrospinal fluid isolated *Proteus mirabilis* and *Bacteroides fragilis*. Intravenous

From the University of Wisconsin Hospitals, Madison.

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Figure 1—Chronically infected neck ulceration with infiltrating carcinoma. Note the radiation hyperpigmentation and spreading ulcers over the posterior thorax.

penicillin G, 5 million units every six hours; gentamicin, 1.7 mg per kg every eight hours; and chloramphenicol, 1.0 gm every six hours, were initiated. A 5-mg dose of gentamicin was injected intrathecally.

Improvement in mental status and absence of fever occurred shortly thereafter. Cervical tomograms, sinusgram of the wound, done twice and xerograms failed to reveal evidence of parameningeal abscess or communication between the neck lesion and the subarachnoid space. In light of the good clinical response and consistently negative cultures from the cerebrospinal fluid, withdrawal of antimicrobials was attempted after two and one half weeks of continuous therapy.

Relapse occurred forcing resumption of antibiotics 48 hours later. A right frontal intraventricular Rickham reservoir was inserted for administration of intraventricular gentamicin (5 mg) every other day. Cultures of the ventricular cerebrospinal fluid isolated *Pseudomonas aeruginosa*. Because of poor clinical response and persistently positive cultures of pseudomonas, polymyxin B (5 mg) intrathecally was initiated.

Again in search of a parameningeal source a complete myelogram was performed revealing changes in the cervical subarachnoid space consistent with severe arachnoiditis with obliteration of the ventral and right subarachnoid space from C_4 to the foramen magnum. Surgery was not attempted because of the extent o the lesion and seemingly direct ex tension of the cancerous ulcer int the subarachnoid space.

Cultures from both ventricular an lumbar cerebrospinal fluid remaine sterile following one week of intra ventricular polymyxin B and intra venous chloramphenicol, gentamicin and penicillin administration. Systemi treatment with chloramphenicol, 1.(gm every six hours, provided cerebrospinal fluid levels of 10-18 mcg pe ml, and intrathecal administration in a dose of 5 mg per kg daily provided cerebrospinal fluid levels of gentamicin greater than 9 mcg per ml. The cerebrospinal Schlicter "cidal" level to *Proteus* was 1:8 and to *Bacteroides* 1:2. When relapse occurred, ventriculitis was suspected; and isolation of *Pseudomonas* from the ventricular fluid confirmed it. Insertion of the Rickham reservoir allowed adequate access for the administration of antibiotics. Polymyxin B, 5 mg through the reservoir every other day, achieved a "cidal" level to *Pseudomonas* of 1:16 dilution. In spite of adequate cerebrospinal fluid levels of antibiotics progressive mental deterioration continued to death four weeks later.

Autopsy revealed continuity of the right neck ulcer with the right hypoglossal canal. Microscopic examination demonstrated the presence of squamous cell carcinoma in the right neck ulcer and on the brain stem. Findings suggested that extension of the squamous cell carcinoma to the brain stem occurred through the hypoglossal canal resulting in continuity of the neck ulceration with a subarachnoid abscess on the anterior aspect of the medulla. In addition, the subdural space over the frontal cerebral lobes, the cerebellar hemispheres and medulla oblongata contained green pus.

Comments

Acne conglobata is a severe form of chronic acne with tendency to the formation of spreading ulcers. Epidermoid carcinoma associated with acne conglobata has been reported in at least three previous cases.[2,3] These cases have been confined to the sacrum, buttocks, or perineum; and treatment consisted of wide surgical resection. In our case the unusual location of the carcinoma in the neck prevented complete resection. Irradiation of the area may well have prevented healing or future attempts to cover the lesion.

The flora infecting the cerebrospinal fluid clearly reflected the same organisms cultured from the neck wound; however, direct seeding into the cerebrospinal fluid could not be demonstrated premortem in spite of a high degree of suspicion and extensive diagnostic measures to demonstrate a sinus tract premortem.

Despite antibiotic therapy, mortality among reported cases of Gram-negative meningitis is high.[4,5] In some instances, as Rahal[6] suggests, inadequate antibiotic coverage may be responsible. However, the final outcome in our case seemed directly related to the underlying disease. Nevertheless, a maximum attempt was made to achieve "cidal" levels of antibiotic throughout the cerebrospinal fluid along with attempts to demonstrate a sinus tract and/or a parameningeal source of infection.

Nonproprietary names and trademarks of drugs:

Penicillin G potassium — same
Chloramphenicol sodium succinate — Chloromycetin® sodium succinate
Gentamicin sulfate — Garamycin®
Polymyxin B sulfate — Aerosporin®

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COMMENTS ON TREATMENT

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Psoriasis treatment —a review

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PSORIASIS VULGARIS is a common skin disorder affecting approximately 2% of the population of the USA. It is characterized by areas of scaling and erythema and may become a severe physical and social problem to the affected person. In some patients there is a significant inheritance of the disease.

Despite much intensive research the basic etiology of psoriasis remains obscure. In addition to cutaneous problems approximately 5% of psoriatics have an associated psoriatic arthritis.

What is known is that affected psoriatic skin is in a state of benign epidermal hyperproliferation and hyperplasia. Most of the currently available treatments are aimed at reducing this hyperproliferation. The turnover time from formation to shedding of an epidermal cell in a psoriatic area is about 7 times more rapid than in normal skin.

The treatment of psoriasis may be divided into the following groups:

1. Milder psoriasis responsive to conventional topical and physical treatments.
2. Severe psoriasis requiring systemic therapy.
3. Photochemotherapy — a recent advance.

CONVENTIONAL TOPICAL TREATMENTS

Coal tar preparations

These preparations have been used for many years in the treatment of psoriasis. Their major drawback is that they are messy and smelly. Many attempts have been made to find a suitable purified coal tar preparation (for example Estar Gel). These purified tar products are occasionally therapeutically helpful, but in general the cruder the coal tar preparation the greater the therapeutic effect.

The concentration of the coal tar is usually between 1% and 5% and it may be used in conjunction with ultraviolet light as the *Goeckerman* regimen originally described in 1925.[1] The ultraviolet lamps used may be either predominantly UVB (or "sunburn") range (290-320 nm) or may be a wider spectrum hot quartz lamp (254-365 nm). The most effective therapeutic wavelengths of light in the Goeckerman treatment are still unclear, however. The tar is applied as a 1% to 5% crude coal tar in petrolatum overnight; in the morning the patient is treated with minimal erythema dosages of ultraviolet light still with the residual tar present on the skin. They then have a tar emulsion (Balnetar, Polytar emulsion) bath and reapply the crude coal tar. This is essentially an inpatient regimen because of the messy nature of the treatment. Occasionally tar products may be skin irritants and may also induce a folliculitis. Interestingly there does not appear to be an increased incidence of skin malignancies in psoriatic patients who have been

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treated with coal tars and ultraviolet light. Goeckerman treatment often leads to long periods of improvement.[2]

Anthralin

This is a high boiling point coal tar distillate that has been used for many years in the treatment of psoriasis. Ingram[3] originally described his method for combining anthralin paste, coal tar baths, and ultraviolet in 1952. This again is essentially a hospital/clinic in- or outpatient therapy.

The patient has a coal tar emulsion bath for 30 minutes followed by exposure to ultraviolet light in minimal erythema dosages. The anthralin in Lassar's paste (zinc oxide 25 gm, starch 25 gm, white petrolatum to make 100 gm) is then applied to the lesions only, covered with stockinette and then removed after eight hours with mineral oil. A talcum powder dusting to the applied paste will help keep its position. Starting anthralin concentrations are usually 0.1% to 0.2% and may be gradually increased to 0.4% or higher. Increases of concentration may be carried out every third day (Figs 1a and 1b).

Occasionally anthralin may irritate, and care should be taken not to contaminate the eyes. Temporary brown staining of normal skin occurs with higher concentrations.

Fairly long remission times are possible—in some studies a mean of 26 weeks.[4]

Topical Steroids

These are probably the most widely used of all topical treatments for psoriasis particularly on an outpatient basis because they are relatively nonmessy and easy to apply.

The more potent steroids are very effective at clearing psoriasis and are to be used in certain situations—for example visually obvious areas of psoriasis and flexural psoriasis.

There are certain problems that are seen with the more potent topical steroids—(a) skin atrophy, (b) "rebound worsening of psoriasis on stopping the steroids, (c) tendency to convert "stable" chronic psoriasis to "unstable" [erythrodermic, pustular] psoriasis, (d) in patients with extensive psoriasis a significant skin absorption and systemic effect may be seen, (e) long-term use of potent topical steroids to the face may lead to a rosacea-like syndrome.

As with all steroid treated dermatoses the plan should be to use the weakest strength of steroid that is able to clear the dermatosis.

There is evidence that adding topical steroids to the Ingram regimen (see above) shortens the remission time of psoriatics significantly.[4]

Table 1 shows a list of approximate relative potency of some commonly used topical steroids. Figure 2 shows the response to topical steroids.

Table 1—Relative potencies of some commonly used topical steroid preparations

1. Lidex Synalar Valisone	Potent
2. Kenalog 0.1%	Medium
3. Kenalog 0.025% Locorten	Milder
4. Hydrocortisone 1%	Weak

SYSTEMIC TREATMENT OF PSORIASIS

Systemic therapy is fortunately only needed in the occasional patient with severe psoriasis.

Indications for systemic treatment in psoriasis

1. Generalized pustular psoriasis.
2. Generalized exfoliative psoriasis.
3. Severe psoriatic arthropathy.
4. Severe uncontrolled psoriasis.
5. Socially incapacitating psoriasis.

Systemic corticosteroids

These drugs—particularly triamcinolone acetonide, prednisone, and ACTH—are occasionally used in the treatment of psoriasis. My own preference is to avoid their use unless the patient has been previously treated with a systemic steroid and has become steroid "dependent."

There is evidence that the use of systemic steroids in psoriasis vulgaris may have led to some cases of severe generalized pustular psoriasis.[5] Occasionally we have to use systemic steroids in the acute disease where other forms of systemic treatment are contraindicated. On attempted withdrawal of a psoriatic patient from systemic steroid treatment a severe worsening of the psoriasis may occur.

Systemic antimitotic drugs

Psoriasis is a disease in which there is an increase in the mitotic rate and DNA synthesis in the epidermis. It is not surprising, therefore, that systemic antimitotic agents have been used in the control of this disease, but it is to be stressed that this group of drugs carries a significant number of potential side effects.

The most used of the antimitotic agents is methotrexate (MTX) and in the USA is mainly used by the oral route, although it may be given by intramuscular or intravenous routes. It is important that pretreatment liver biopsies be taken and show no evidence of hepatic fibrosis (a significant potential side effect of MTX). In addition normal blood counts, platelets, hepatic function, and renal function must be confirmed before treatment. If needed for psoriasis, then MTX should if possible be reserved for chronic unresponsive psoriasis in patients past the reproductive age; and the patient must be willing to attend hospital at weekly or two weekly intervals.

Oral regimens may be either three doses per week spaced at 12 hourly intervals—this follows the finding that the mean epidermal cell cycle time in psoriasis is 37½ hours[6]—however, there has been recent controversy over this cell cycle time and my own preference is to use MTX once weekly by mouth. If there is extensive psoriasis, then there may be an impaired absorption of MTX because of the so-called dermatogenic enteropathy. I then prefer to start MTX therapy

Figure 1a—A large plaque of psoriasis vulgaris showing the thickened erythematous scaling.

Figure 1b—The same plaque with anthralin paste applied.

intravenously once weekly and transfer to an oral regimen once the condition has improved. Usually a test dose of 7-12.5 mg is given and the patient response observed over the next five to seven days. A complete blood cell count should be checked at each visit and SMA-12 checked regularly.

Other antimitotic drugs

Other antimitotic drugs used over the years in the treatment of psoriasis include azathioprine, hydroxyurea, cyclophosphamide, azaribine—however, none have either been as successful as MTX or have had serious side effects (for example the thromboembolism from azaribine). Recently mycophenolic acid has been used in the systemic treatment for psoriasis, but there is a very high incidence (about 30%) of diarrhea and other symptomatic gastrointestinal effects plus an increase in viral infections, neutropenia, and possibly associated carcinoma.[7]

PHOTOCHEMOTHERAPY OF PSORIASIS

Photochemotherapy is a significant alternative treatment for recalcitrant and severe psoriasis. This involves the use of the photosensitizing agents—psoralens (P) and long wave length (320-400 nm) ultraviolet light or UVA. P + UVA = PUVA. This treatment was originally described using topical methoxsalen and UVA by Walter et al in 1973.[8] In 1974 a group from Boston described the use of oral methoxsalen and UVA in a number of psoriatics.[9] Since then many centers have begun to treat some psoriatic patients with PUVA.

At present we do not know if we are going to see late side effects from this treatment and probably will not know for the next 15 years or more.

Psoralens have been used for many years in the treatment of vitiligo and so the new and unknown quantity of PUVA is really the high intensity UVA light sources that are necessary to produce a good therapeutic response. There is hope, however, that the lights will not be carcinogenic as the principal carcinogenic spectrum for skin is thought to be UVB. Theoretically we may see premature skin aging from the dermal effects of the UVA.

Until longer term studies are available PUVA should probably only be available at centers that have the facilities to carefully monitor the patients.

We have approximately 170 psoriatics that have had or are having PUVA at the University of Wisconsin Hospitals, Madison. We have not observed any significant side effects over a two-year period in these patients, and a number of

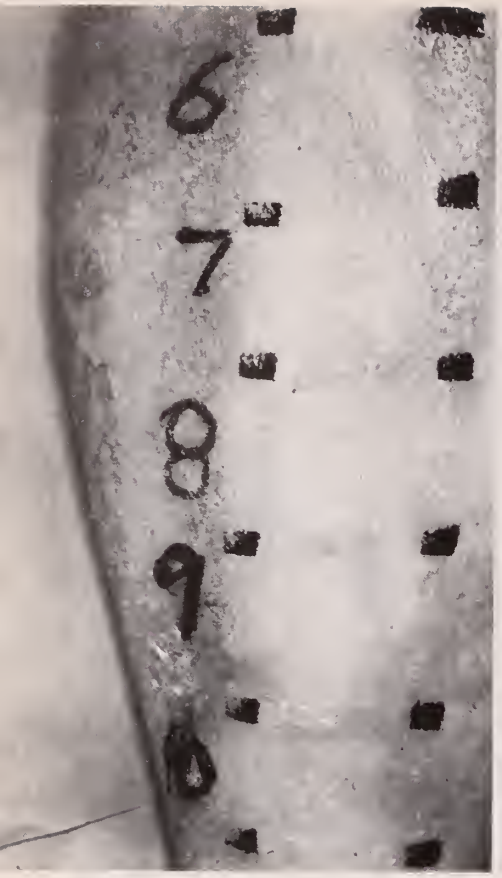

Figure 2—A plaque of leg psoriasis showing the therapeutic effects of topical steroids under occlusion daily for five days. Control sites 6 and 7. Site 8—Triamcinolone cream 0.5%. Site 9—Triamcinolone cream 0.1%. Site 10—Triamcinolone cream 0.025%.

MTX or systemic steroid treated patients have been switched to PUVA. Early and usually mild transient side effects are pruritus and erythema. Occasionally nausea is a problem.

However, PUVA at present should be reserved for—

1. Generalized pustular psoriasis.
2. Exfoliative psoriasis.
3. Severe or recalcitrant psoriasis resistant to topical therapy.

PSORIASIS IN SPECIAL SITES

Palmar and *plantar psoriasis*—there are several different types of "psoriasiform" skin diseases localized to the palms and soles. Often there is a significant degree of pustulation and hyperkeratosis. Local treatment—potent topical steroid creams under Saran Wrap (or plastic gloves) often help the condition. 5% coal tar in Lassar's paste or the anthralin preparations are sometimes useful (at night as they are very messy).

Local PUVA is being evaluated. These types of psoriasis are frequently resistant to treatment.

Face and *flexures*—topical steroids. NOTE: Steroid-induced atrophy and rosacea-like dermatitis of the face.

Scalp—mild: Bakers P & S applied at night and shampooed with tar shampoo in the mornings. *Severe* (thick scaling): 5% coal tar and 5% salicylic acid ointment overnight. Mineral oil to scalp in morning to "loosen" ointment, then shampoo with tar shampoo. Very messy but effective. Alternative: 0.4% anthralin pommade at night.

Widespread erythematous and fine scaling scalp psoriasis—steroid lotions applied twice daily (Valisone lotion). Tar shampoo nightly (Polytar, Sebutone, X-SEB T).

Nail psoriasis—treatment is often disappointing, but psoriasis nail dystrophy often improves as the psoriasis improves. Local treatment with triamcinolone injection around the nails occasionally improves the nail dystrophy.

THE TREATMENT OF PSORIASIS MAY BE SUMMARIZED:

1. This is a chronic disease, hence constant reassurance important. No permanent cure is available but in most patients it *is* possible to achieve complete clearance for a time.
2. *Complications* such as generalized erythroderma, arthropathy, pustulation, are best treated in hospital.
3. Use of *cytotoxic* or *photocytoxic* (PUVA) therapy for the severe, intractable, or potentially lethal forms does require hospital or clinic supervision, for obvious reasons.
4. *Steroids*—systemic use in the past frequently led to a severe relapse on withdrawal. Now rarely indicated.
5. *Topical steroid* treatment, under polythene occlusion or with very potent topical steroids without occlusion, very effective but remission times are often relatively short and occasionally severe relapse on withdrawal makes the disease "unstable."

HOPES FOR THE FUTURE

The major hope would be for the basic primary defect in psoriasis to be discovered. Is this defect epidermal or dermal? Is it a result of abnormal dermal vasculature? Is it a result of an abnormal biochemical pathway in the epidermis; for example, defective enzyme function? If this basic question could be found, then advances in therapy are possible. Until then the search for an effective, safe, nonmessy topical antimitotic agent should continue. For example, it was found that 5-fluorouracil cleared psoriasis but unfortunately caused skin ulceration of the psoriatic plaques and, therefore, is of no value.

Will newer topical steroids be found that are effective but have less of an effect on producing dermal atrophy? Until these agents are available, the presently available therapy should be monitored closely and modified where necessary.

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Oral contraceptive induced hypertension simulating primary aldosteronism

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• A 26-year-old woman who had been taking an oral contraceptive preparation for two years presented with accelerated hypertension. Laboratory investigations revealed persistent hypokalemia, large urinary potassium loss, suppressed plasma renin activity, and markedly elevated urinary aldosterone excretion, all pointing towards a diagnosis of primary aldosteronism. However, the blood pressure fell considerably and the laboratory abnormalities disappeared eight weeks after discontinuation of oral contraceptive therapy. It is suggested that one should wait six to eight weeks after oral contraceptives are withdrawn before studying the renin-angiotensin-aldosterone system for secondary hypertension.

It has been well documented that oral contraceptives cause hypertension including malignant hypertension.[1] Although the exact mechanism by which these agents elevate the blood pressure remains uncertain, estrogens are known to cause a rise in renin substrate.[2] Beckerhoff reported increases in renin substrate, renin activity, and plasma aldosterone in 10 normal women administered oral contraceptive therapy.[3] However, Weir, Tree, and Fraser did not find a significant rise in plasma aldosterone among patients receiving oral contraceptives.[4] We report herein a patient who presented with hypertension and laboratory findings of primary aldosteronism in whom the blood pressure fell considerably and the laboratory abnormalities disappeared upon discontinuation of oral contraceptive therapy.

Case report

A 26-year-old white woman was first seen in October 1975 for blurred vision of two months duration. In addition, she suffered intermittent frontal and occipital headaches of two years duration. These had become more severe in the previous two months in association with anxiety, nervousness, palpitations, and sweating. She suffered bronchial asthma since childhood which required Tedral® (theophylline 130 mg, ephedrine hydrochloride 24 mg, and phenobarbital 8 mg) and prednisone 5 mg daily. Her father, age 51, had mild essential hypertension and mother, age 49, had bronchial asthma. Her blood pressure had been recorded at 120/80 mmHg in September 1973. At this time Ortho-Novum® (norethindrone 2 mg, mestranol 0.1 mg) was prescribed for contraception.

Physical examination revealed a blood pressure of 230/140 mmHg supine in both arms with no significant postural change. The pulse rate was 120 and regular. She was apprehensive and perspired profusely. The thyroid gland was slightly enlarged, but symmetrical without nodules. The optic fundi revealed flame-shaped hemorrhages and soft fluffy exudates bilaterally without papilledema. A hyperdynamic cardiac impulse was felt in the fifth left intercostal space at the mid clavicular line. The physical examination was normal otherwise.

The patient was hospitalized and all medication discontinued except Tedral® tablets four times daily. The blood pressure was measured between 150/120 and 190/130 mmHg during the first three days.

Laboratory investigations revealed: hemoglobin, 14.1 gm per dl; urinalysis—specific gravity 1.026, no sugar, albumin or casts; 2 to 4 white blood cells and 1 to 2 red blood cells per high-power field. The urine culture was sterile. Serum creatinine was 0.8 mg per dl; and serum electrolytes—sodium 142, potassium 3.0, chloride 102, and bicarbonate 27.9 mEq per liter. Two days later a repeat serum potassium measured 3.2 mEq per liter and 24-hour urinary potassium excretion was 63 mEq.

Chest x-ray film, electrocardiogram, hypertensive intravenous pyelogram, and ^{131}I hippuran renogram were normal. The 24-hour urinary excretion of vanillylmandelic acid and catecholamines was normal. Thyroid function studies also were normal.

On a normal sodium regimen of 150 mEq per day, 24-hour urinary aldosterone was 79 mcg (normal: 2-20 mcg) and plasma aldosterone was 28.6 ng per dl (normal: 5-30 ng). After three days of a 20 mEq per day sodium regimen, 40 mg furosemide intravenously, and ambulation for 4 hours, the plasma renin activity as determined by radioimmunoassay was 1.14 ng per ml per hour (normal: 3.96 to 8.1 ng per ml per hr).

Initially the blood pressure was reduced from 190/130 mmHg to 130/85 mmHg by 1 mg daily intramuscular reserpine. After obtaining the laboratory tests as specified above reserpine was discontinued, and she was administered 1 tablet Aldactazide® (hydrochlorothiazide 25 mg and spironolactone 25 mg) and 250 mg alpha-methyldopa daily. Blood pressure remained at 120/80 mmHg with this therapy for three days, and she was

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discharged from the hospital on these medications. Our initial impression was that this patient had primary aldosteronism. Subsequently previous antihypertensive therapy was discontinued and spironolactone 200 mg daily was prescribed. Despite four weeks of spironolactone therapy, the blood pressure increased to 150/100 mmHg. All medications were discontinued and she was hospitalized again for adrenal venography and sampling of adrenal venous blood for differential aldosterone measurements. Aldosterone levels in blood obtained from both adrenal veins and inferior vena cava above and below the renal veins were within normal limits. The adrenal glands appeared normal in size and shape on the venogram. Urinary aldosterone and plasma aldosterone measurements were repeated and found to be 16.1 mcg per 24 hours and 13.1 ng per dl respectively, both within normal limits. The patient was discharged.

Eight weeks later on a daily 1.0 gm sodium regimen as an outpatient a repeat urinary aldosterone measurement was 7.6 mcg per 24 hours and the plasma aldosterone was 10.7 ng per dl. Presently her blood pressure is well controlled with one tablet of Aldactazide® and 250 mg alpha-methyldopa daily. In addition, she is receiving Tedral® tablets and prednisone daily for control of asthma. She is asymptomatic and her optic fundi have returned to normal.

Discussion

The development of severe or malignant hypertension is an unusual occurrence in patients taking oral contraceptive agents.[1] Although our patient was normotensive before starting oral contraceptive therapy, it was felt that a diagnosis of oral contraceptive-induced accelerated hypertension should not be entertained before appropriate investigations were undertaken to rule out other causes of secondary hypertension. Unprovoked and persistent hypokalemia associated with a large urinary potassium loss, suppressed plasma renin activity, and elevated urinary aldosterone excretion all pointed towards a diagnosis of primary aldosteronism. However, these values returned to normal eight weeks after discontinuation of oral contraceptive therapy. Although we would have wished to challenge the patient again to see if hypertension and the laboratory picture of primary aldosteronism recurred, it seemed unjustifiable to reintroduce oral contraceptives since irreversible renal failure has been reported on repeat oral contraceptive therapy.[5]

Estrogens have been demonstrated to increase the hepatic synthesis of renin substrate. This in turn may lead to elevation of plasma renin activity and increased aldosterone excretion.[3] However, Crane et al[6] have demonstrated hyporesponsiveness of plasma renin activity and normal aldosterone levels in patients treated with oral contraceptives three to six weeks after discontinuation of therapy. Our patient demonstrated very low plasma renin activity and high urinary aldosterone excretion just four days after discontinuation of oral contraceptives.

Synthetic progestational compounds such as norethindrone have been found to cause salt retention.[6] This may partially explain the low plasma renin activity but would not explain the high aldosterone excretion.

The striking activation of the renin-angiotensin-aldosterone system due to oral contraceptive therapy is usually well compensated. Cain et al[7] suggest that although all are susceptible, only those with underlying renal disease preventing the full expression of various compensatory mechanisms may develop hypertension. Although our patient did not have renal disease, she may have been susceptible to hypertension because of therapy with epinephrine analogs and prednisone for bronchial asthma.

From a diagnostic standpoint it is important to realize the alterations in renin-angiotensin-aldosterone system due to oral contraceptives may be similar to those of primary aldosteronism. One should wait six to eight weeks after medications are withdrawn before studying the renin-angiotensin-aldosterone system for other forms of secondary hypertension.

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ABSTRACT/ WISCONSIN AUTHORS

Typical and atypical ('silent') subacute thyroiditis in a wife and husband

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Typical subacute thyroiditis was diagnosed in a woman. Three weeks later, signs and symptoms of hyperthyroidism developed in her husband. Although the right lobe of his thyroid gland was slightly enlarged, pain and tenderness were absent throughout the course of his illness. The free thyroxine equivalent (FTE) value and the sedimentation rate were elevated; the low uptake of radioactive iodine by the thyroid gland was consistent with 'silent' subacute thyroiditis. We postulate that a common etiology, probably viral, was operative in both cases.

Nine additional cases of hyperthyroidism with low levels of thyroidal uptake of radioactive iodine also were described. The thyroid glands of these patients were normal or slightly enlarged. Antithyroglobulin antibody levels determined in seven patients were not substantially elevated. The clinical course of these patients was characteristic of 'silent' subacute thyroiditis. Although the origin of the syndrome remains unclear, the disease is self-limited and therapy, if any, is supportive. ■

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When should a joint replacement be performed?

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THE GREAT BENEFITS of joint replacement surgery are now well known, but this surgery is not without significant potential complications. The usual operative complications of any major surgical procedure exist. In addition, joint replacement may be followed by unique late complications. The two main late problems are component loosening and infection. Infection may occur any time after surgery. Many late infections are felt to be hematogenous in nature. Therefore, joint replacement should not be undertaken lightly.

To date the joint most frequently replaced has been the hip joint. It has been followed the longest time and has enjoyed the most success. Knee replacement is second to the hip in all respects with the ankle being third. Elbow and shoulder replacement still need much refinement. The silastic implants for the hand do not utilize methyl methacrylate for fixation and therefore are not included in this discussion.

This discussion will emphasize the selection of candidates for total joint replacement and the presentation of the surgical option to the patient.

If no life-limiting condition or activity-limiting disease exists, age is still a definite factor in patient selection. With isolated joint damage in an otherwise healthy person, few indications exist for joint replacement in people under age 60. This policy does not exclude the patient with rheumatoid arthritis involving many joints for whom no other therapy exists.

Joint replacement is performed to diminish pain and increase function and not to treat radiographs. Radiographs may be misleading because, frequently, severe arthritis exists on the radiograph, but yet the patient is very satisfied with his existence. Thus, it is the physician's job to assess the degree of pain and the limitation of function.

The amount and type of analgesic medication is often a good index of pain severity. The patient with night pain in spite of codeine administration is a much more likely candidate for surgery than the patient with discomfort that is relieved by aspirin after walking 18 holes of golf. Patients with both types of pain present as candidates for total joint replacement.

The physician also must assess how the damaged joint limits the patient's life. Does the pain and stiffness impair or prevent ordinary activities like driving, sleeping, dressing, or keeping house? The answers to these questions are important. Surgery to enable a patient to perform these functions I consider very reasonable, while I consider replacement surgery with existing techniques to allow a 45-year-old man to play a better game of tennis completely unreasonable.

If the physician feels that the pain and impairment are sufficient to warrant undertaking the risks of operation, the procedure should be offered and not recommended to the patient. This offer is made only after the patient has been informed of the risks and reasonable expectations of the operation. Reasonable expectations should not include vigorous impact-producing activities. Implant failure more often occurs in large, heavy, and active people.

Too often a patient feels obligated to have an operation he really doesn't desire because it has been recommended by a physician or strongly suggested by a relative. Because a procedure performed for comfort and function is elective, the patient should make the final decision. Arthritis will not kill the patient but an operation can.

Joint replacement is certainly the most significant development to date for the treatment of damaged joints. Its availability should not obscure the fact that most damaged joints can be treated nonoperatively. Nor should more conservative procedures such as osteotomy and synovectomy be discarded. If the discussed guidelines are followed, the appropriate patients will receive total joints. Those with successful operations will enjoy the increased comfort and function, and those with complications will most often accept them as they will be little worse off than they were before having had an operation that they chose. ■

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PERINATOLOGY

Respiratory distress in the "term" neonate

Richard D Zachman, PhD, MD, Madison, Wisconsin

IT HAS BEEN CUSTOMARY to think of respiratory distress as a syndrome affecting premature babies only. For a number of years, however, evidence has been accumulating to indicate that a significant number of term babies also are prone to develop respiratory distress. The present article summarizes the conditions which predispose the term infant to pulmonary problems and gives general guidelines for treatment.

Table 1—Respiratory distress in the "term" neonate

Etiology of respiratory distress	*Principal associated clinical findings*	*Intensive care admissions (% of cases)*
Asphyxia neonatorum		8%
a) Intrapartum hypoxia	Toxemia, postmaturity, cord compression, bleeding	
b) Birth trauma	Facial edema, shoulder dystocia	
Surgical emergencies		10%
a) Pneumothorax	Displaced apical beat, decreased breath sounds	
b) Diaphragmatic hernia	Scaphoid abdomen, bowel sounds in chest	
c) Tracheal-esophageal fistula	Excessive oral pharyngeal mucus, choking with feeding	
Medical conditions		
a) Meconium aspiration	Meconium stained infant—increased AP diameter of chest	28%
b) Wet Lung (transient tachypnea)	Cesarean section or precipitous delivery—high chest, shallow respirations	24%
c) Pneumonitis	History of premature rupture of membranes, Tachypneic and shocky	14%
d) Aspiration (other)	Tachypnea, clear amniotic fluid	10%
e) Iatrogenic RDS (Hyaline Membrane Disease)	Elective Cesarean section without amniotic fluid maturity studies, questionable maternal dates	6%

EVERYONE DELIVERING perinatal care needs to be capable of making an early diagnosis and promptly treating the term infant who presents in the delivery room or nursery with respiratory distress. In the last two years, there have been 111 term neonates ($\geq$ 37 weeks gestation) with respiratory distress admitted to our special care nursery —so the problem is more common than one might expect. Table 1 lists several causes for term neonatal respiratory distress, indicates the principal clinical findings at birth, and shows how those admissions to our program were distributed.

Asphyxia neonatorum requires immediate and efficient resuscitation. Oxygen must be administered rapidly since the newborn has no oxygen reserve. The pulmonary circulation will relax only after effective ventilation with bag and mask or with an endotracheal tube.

Spontaneous symptomatic pneumothoraces can occur in the neonate, or may result from resuscitation efforts. After diagnosis, action should include raising the ambient oxygen until the baby is pink. If the chest film confirms the diagnosis, and the baby remains asphyxiated and is not improving, one must consider needle aspiration of the chest or a chest tube placement.

Diaphragmatic hernia, where the abdominal contents have gone through a defect in the diaphragm causing a shift in the mediastinum and compression of the contralateral lung, is a surgical emergency. These babies always should be intubated, and not resuscitated using

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mask ventilation. Mask ventilation blows air into the gastrointestinal tract, thus further compromising the baby's respiratory status. Nasogastric suction should be initiated. Immediate surgery is necessary since severe hypoxia and acidosis can occur in a short time.

Tracheo-esophogeal fistula is another neonatal surgical emergency presenting as respiratory distress in the term neonate. A plain x-ray without using any contrast media usually confirms the diagnosis. Suction of the upper pouch is recommended while the baby is being prepared for surgery.

The single most frequent cause of respiratory distress in the term neonate is meconium aspiration. However, the mortality and morbidity associated with meconium aspiration can be reduced significantly if tracheal suction is performed on all infants born through thick meconium stained fluid. Pneumothoraces are frequently associated with meconium aspiration. Neonatal aspiration of clear amniotic fluid or mucus also can lead to respiratory distress.

"Wet lung" disease is different from aspiration. This occurs when the fluid present in the fetal lung is slowly absorbed after birth. This most often occurs in Cesarean section deliveries because of bypassing the usual pressures on the fetal chest during birth that ordinarily push out this pulmonary fluid. This retained pulmonary fluid must then be absorbed by the pulmonary lymphatic system—and during that time the neonate frequently shows signs of respiratory failure.

Pneumonitis can be caused by a variety of organisms, contracted from the mother either in utero or during birth. The most frequent and lethal agent in the 1970s is the nongroup A, beta-hemolytic streptococcus. Respiratory failure, a fulminating course, and shock are the hallmarks of this serious disease.

Iatrogenic hyaline membrane disease accounted for 7 of the 111 admissions to intensive care for respiratory distress in "term" neonates. In 6 of these cases, an elective Cesarean section was done without determination of fetal lung maturity (amniotic fluid lecithin sphingomyelin [L/S] ratio). In some of these, and one elective induction, the obstetrically estimated gestational age was 2 to 4 weeks greater than the pediatric estimation of gestational age. Hence, this problem could totally be avoided by determining fetal lung maturity in such situations.

In summary, respiratory distress in the term neonate is a relatively frequent and serious problem. Those persons immediately available can do a great deal of good by making an early diagnosis and initiating life-saving measures, especially good resuscitation. Some cases can be treated by support with increased ambient oxygen. Many others require transfer to another facility for surgery and intensive care. ■

SPECIAL TO THE JOURNAL

THE RELEASE OF STREPTOKINASE

Richard D Sautter, MD, Marshfield, Wisconsin

HAVING CAST THE one "no" vote at the Advisory Committee to the FDA considering the release of streptokinase, I feel compelled to publicly express my concern. Our institutions were involved in several multicenter trials involving lytic agents (the Urokinase Pulmonary Embolism Trial—UPET: Urokinase-Streptokinase Pulmonary Embolism Trial—USPET; Streptokinase-Urokinase Myocardial Infarction Trial—SUMIT). We have had considerable experience with the use of streptokinase and urokinase in the treatment of pulmonary embolism.

There are several concerns:

(1) *Efficacy*—There is no scientific evidence to indicate that the use of lytic agents affects mortality or morbidity.

During the FDA hearing this problem was managed semantically by using the term "pharmacological efficacy." Lytic agents do accelerate the lysis of fresh pulmonary emboli but whether morbidity and mortality are affected has not been demonstrated.

(2) *Diagnosis of Pulmonary Embolus*—The diagnosis of pulmonary emboli can be positively confirmed only by pulmonary arteriography. I fear some physicians may use lytic agents to treat patients with less than a positive diagnosis.

It is important to remind physicians that the clinical diagnosis of pulmonary emboli is very uncertain; pulmonary scintillation scanning is inaccurate in 15-20% of the patients studied; the error using this modality increases if the patient is in a postoperative period.

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For a patient to receive a potent lytic agent such as streptokinase and be subjected to the attendant risk of bleeding with less than a positive diagnosis is reprehensible.

(3) *Size and Maturity of Pulmonary Emboli*—If acceleration of lysis of a pulmonary embolus is to affect morbidity and mortality, the amount of obstruction within the pulmonary artery and the maturity of the pulmonary embolus are important variables.

In this regard, there are important facts to be considered.

a) All pulmonary emboli will spontaneously undergo lysis if given enough time and if recurrent pulmonary emboli are prevented.

b) Obstruction of less than 50% of the pulmonary artery seldom affects cardiorespiratory stability in patients with no previous cardiorespiratory disease.

It would seem extremely unwise to subject a patient to the risk of lytic agents if obstruction in the pulmonary artery is minor.

Clinicians should also remember that the more mature the pulmonary embolus, the less effective lytic agents become in accelerating lysis. Certainly, the five days suggested in the drug insert is a maximum after which lytic agents are likely to be ineffective.

(4) *Bleeding*—The use of lytic agents is more likely to produce significant bleeding than the use of heparin. This rather simple fact, (stated in the drug insert) may be overlooked or ignored by physicians unfamiliar with the use of these agents. Clinicians also should be aware that it is more difficult to reverse a lytic state than it is to reverse the effect of heparin.

It is true that if contraindications are strictly followed and the induced thrombogenesis carefully monitored, bleeding can be kept at an acceptable level.

It is important also to remember that there is no question that patients bleed more often and in greater amounts in an active thrombolytic state than those who are given therapeutic doses of heparin.

Clinicians contemplating the use of streptokinase should be cautious to assure an appropriate risk: benefits ratio for their patients. For those inexperienced in the use of such agents, medicolegal implications should be evaluated. The pharmaceutical companies should be aware that a potentially useful drug may very quickly gain a poor or, at best, controversial reputation as to utility. Of even greater importance, is that the NIH should be involved in the development of further trials to determine exactly what thrombotic conditions warrant lytic therapy. ■

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ABSTRACT / WISCONSIN AUTHORS

Is staging laparotomy in cervical cancer justifiable?

MICHAEL KADEMIAN, MD and ANTONIO BOSCH, MD, University of Wisconsin Center for Health Sciences, Madison, Wis: *Int J Radiation Oncology Biol Phys* 2:1235-1238, 1977

Although surgical staging is more accurate than clinical staging in squamous-cell carcinoma of the cervix, this fact alone cannot be used to justify exploratory laparotomy. Conventional radiation therapy in cervical cancer routinely demands pelvic doses which are limited by normal tissue tolerance. The only information gained by exploratory laparotomy which might alter therapy significantly is the discovery of periaortic nodal metastases or other disease outside the pelvis.

An analysis of previously reported large series indicates that pelvic therapy constitutes the overwhelming majority of treatment failures in carcinoma of the cervix. Control of periaortic disease, if possible, will not increase cure rates since failures will likely occur in the pelvis anyway. The chances of controlling periaortic metastases are small, and combined surgical exploration and radiation therapy increases complications.

Analysis of data previously reported in the literature, indicates that there is no theoretical possibility of increasing survival in squamous cell carcinoma of the cervix by doing a pretreatment exploratory laparotomy. An analysis of preliminary reports of patients undergoing exploratory laparotomy shows no increase in cure rate. Routine use of exploratory laparotomy in cervical cancer is not justifiable based on data about the disease which is already available and has been reported in the literature.—DOROTHY J BUCHANAN-DAVIDSON, PHD ■

HYPERTENSION CONTROL IN WISCONSIN

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A RECENT COMMUNICATION from the National High Blood Pressure Education Program of the National Heart, Lung and Blood Institute indicates that well over 50 million people in the United States may have elevated blood pressure. This is much higher than the previously publicized figure of 23 million.[1] The latter figure was based on the National Center for Health Statistics data which described civilian, non-institutionalized persons between the ages of 18 and 74 years who had definite high blood pressure (BP $\geq$ 160 mmHg systolic and/or $\geq$ 95 mmHg diastolic).[2]

The figure 23 million has been widely reported but did not include: (1) persons over the age of 74 years; (2) persons under the age of 18 years; (3) persons on adequate treatment for high blood pressure; (4) persons with borderline hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic but < 160 mm Hg systolic and < 95 mmHg diastolic); (5) persons residing in institutions; and (6) persons with normal blood pressure levels and not on medications, who were told by a physician that they have high blood pressure.

Applying the national statistics to the Wisconsin population means that there are approximately 1 million people in the State who have elevated blood pressure which may require treatment and/or followup.

The Milwaukee Blood Pressure Program was initiated in October 1973 to conduct blood pressure screening, public and professional education, referral of newly identified hypertensives to physicians and clinics for control of hypertension, and followup of these individuals in cooperation with their physicians for periodic self-evaluation. The Program was originally funded by the Wisconsin Regional Medical Program and donations from the pharmaceutical industry. It is now funded by the local philanthropic foundations and Federal monies channeled through the State Department of Health and Social Services. To date approximately 185,000 people have been screened for hypertension. Those found to have elevated blood pressure on the first screening are asked to return for a second and possible third screening. If the blood pressure is elevated on two readings, taken at least 24 hours apart, the individual is referred for evaluation and care. Twenty-five percent of those screened were found to have hypertension. To date more than 5,000 people with newly identified hypertension have been successfully referred.

The First National Hypertension Control Conference sponsored by the Milwaukee Blood Pressure Program and hosted by the Northwestern Mutual Life Insurance Company was held in Milwaukee in March 1975. It was attended by more than 300 health professionals from across the nation. The conference is now held annually under sponsorship by the National High Blood Pressure Education Program. It provides a forum for discussion of the multidisciplinary approach to hypertension detection and control.

In conjunction with its Student Health Department the Milwaukee Blood Pressure Program has established a hypertension detection, referral, and treatment program for the University of Wisconsin-Milwaukee students. More than 6,000 students have been screened and approximately 250 newly identified hypertensives have been referred for therapy to their personal physicians or the Student Health Department.

An extensive hypertension detection, health education, and referral program was conducted jointly by the Milwaukee Blood Pressure Program and the Medical Department of the Allis-Chalmers Company for its employees.

New information on the epidemiology of hypertension has emerged from analysis of the Milwaukee Blood Pressure Program data and has been published.[3] Hypertension control in the community has improved since 1974 when 45% of those with elevated blood pressure were found to be unaware of their condition and only 39% were receiving treatment. In 1977, 33% of the hypertensives were unaware of hypertension

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and 52% were on treatment. In 1977 deaths due to heart attacks in Milwaukee were down by almost 17% as compared to the average of the years 1971-73. The stroke deaths were reduced by more than 38%—twice the national average in just four years.

The Hypertension Section of the Medical College of Wisconsin has hypertension clinics at the Downtown Medical and Health Services, Milwaukee County Medical Complex, and the Wood VA Hospital. Approximately 2,000 hypertensives are under active followup for hypertension control at these clinics. In addition to patient care these clinics provide opportunity for medical education and hypertension and health-care research. In these clinics the nurses have been trained to assume an expanded role. They assist in patient education, counseling, and followup. This has greatly improved patient compliance and hypertension control. The data suggest also that physicians in private practice need to prescribe antihypertensive medications more aggressively and should utilize the talents of their office personnel to improve patient education and compliance.[4]

A statewide hypertension control effort, the Wisconsin Blood Pressure Program, was launched in January 1978 to encourage and coordinate hypertension control activities throughout the state. It has an advisory council with statewide representation. This program also coordinates public and professional education on hypertension conducted by the Medical College of Wisconsin, American Heart Association/Wisconsin Affiliate, and the University of Wisconsin-Madison.

Coin-fed blood pressure measuring machines have appeared in drug stores, shopping centers, and department stores in and around Milwaukee. Before long they will be installed throughout Wisconsin. Presently they are the center of a growing controversy.[5] The Chicago Board of Health, after a four-month investigation concluded, "In general the machine has a fair degree of accuracy." However, there is no supervision and mechanism for referral and followup. Also, there is no way of knowing how well the company performs maintenance to assure accuracy. A possible solution to these problems will be to devise ways for local supervision and interpretation of blood pressure readings and appropriate referral for proper evaluation and care.

Detection and control of hypertension is a joint responsibility between the public and the health professionals. Individuals must become and remain aware of the need to have blood pressure checked regularly. Those found to have elevated readings must receive appropriate counseling, evaluation and followup care. Government, employers, health and life insurers, and practicing physicians must do everything possible to facilitate this process. In addition to hypertension control other risk factors, such as obesity, heavy smoking, excessive alcohol consumption, and elevated cholesterol, also must be addressed jointly.

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Thyroid uptake of radioactive iodine in hyperthyroidism

PHILIP L HOOPER, MD and ROBERT H CAPLAN, MD, Gundersen Clinic Ltd and LaCrosse Lutheran Hospital, LaCrosse, Wis: *JAMA* 238:411-413 (Aug 1) 1977

We compared the 24-hour uptake of radioactive iodine (RAIU) in hyperthyroid patients diagnosed from 1970 to 1972 and from 1975 to 1976. Mean RAIU decreased in patients with Graves' disease from 51.1 to 43.8%; mean RAIU in patients with toxic nodular goiter (TNG) fell from 37.3 to 21.1% ($p<.05$). The number of false negative tests increased from 3 to 14% and 20 to 80% in patients with Graves' disease and TNG, respectively.

In 1969 we reassessed the RAIU values in 44 euthyroid subjects. The normal range decreased from 15 to 45% to 0 to 24%. Mean urinary iodine (351 ± 290μg/24 hr) and iodine kinetic studies in these subjects were compatible with high intake of dietary iodine. In 1974, urinary excretion of iodine in 15 euthyroid subjects was 571 ± 283 μg/24 hr, which is significantly higher ($p<.05$) than the mean of 1969. Direct chemical analysis of hospital diets without added salt showed amounts of 246 to 1531 μg of iodine per day.

We conclude that increasing dietary intake of iodine has diminished RAIU in hyperthyroid patients as well as euthyroid subjects. Despite a reestablishment of the normal range, RAIU is within the expected range in a substantial number of hyperthyroid patients. Further readjustment of the normal range is not likely to improve the diagnostic sensitivity of the test, and the diagnosis of hyperthyroidism is currently best made by measurements of circulating thyroid hormones. The RAIU, however, should be performed before radioactive iodine therapy because it is necessary in calculating the therapeutic dose. ■

Correlative study of the treadmill stress test and coronary arteriography in patients with suspected coronary artery disease

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• One hundred and seventy-five consecutive patients with suspected coronary artery disease attempted a maximal treadmill stress test to evaluate electrocardiogram (ECG) and anginal responses. The tests were then correlated with the coronary arteriography findings. Electrocardiogram false positive percentage was 12% and the false negative 26% for a sensitivity of 64%, specificity of 60%, and predictive accuracy of 80%. Maximal treadmill stress test angina was present in 82% of patients with classical angina and significant disease and 80% had a positive maximal treadmill stress test electrocardiogram.

It is concluded that the maximal treadmill stress test is a useful adjunct to the diagnosis of coronary artery disease, but it does not replace coronary arteriography in the definitive diagnosis of presence, absence, or extent of suspected coronary artery disease.

THE TREADMILL STRESS test has effectively replaced the Master's test in recent years as the standard exercise testing method for detection of ischemic heart disease. Submaximal and maximal treadmill stress protocols have been utilized in an attempt to detect the presence, absence, or subsequent development of coronary artery disease.[1-4] The maximal treadmill stress test appears to be predictive in the evaluation of asymptomatic populations with a low prevalence of coronary disease, but these results are limited by the lack of angiographic documentation of the presence or severity of coronary disease.[5-7]

Patients with chest pain should have a high prevalence of coronary disease and the results of exercise testing should reflect this expectation. A variety of other factors, however, may adversely affect the expected high sensitivity, specificity, and predictive accuracy in this group of patients (Table 1).

The purpose of this paper is to examine the relationship between the results of maximal treadmill stress testing and the clinical, angiographic, and hemodynamic parameters in a series of consecutive patients undergoing stress testing, cardiac catheterization, and coronary arteriography.

Materials and Methods

Data on 175 consecutive patients who had cardiac catheterization and selective coronary arteriography 24 hours after completing a maximal treadmill stress test are included in this report. Patients with associated conditions (valvular, congenital, hypertensive heart disease, and claudication, anemia, thyrotoxicosis, etc) known to affect exercise performance were excluded from the study. Arteriographic examination was performed to establish or ex-

Table 1—Definition of key terms used in the text

Sensitivity = The percentage of patients with disease correctly identified by an "abnormal" test.

$$\frac{\text{true positives}}{\text{true positives + false negatives}}$$

Specificity = The percentage of patients without disease correctly identified by a "normal" or negative test.

$$\frac{\text{true negatives}}{\text{false positives + true negatives}}$$

Predictive Accuracy = A measure of how well a test can forecast the development or presence of a condition in the population under study.

$$\frac{\text{true positives}}{\text{true positives + false positives}}$$

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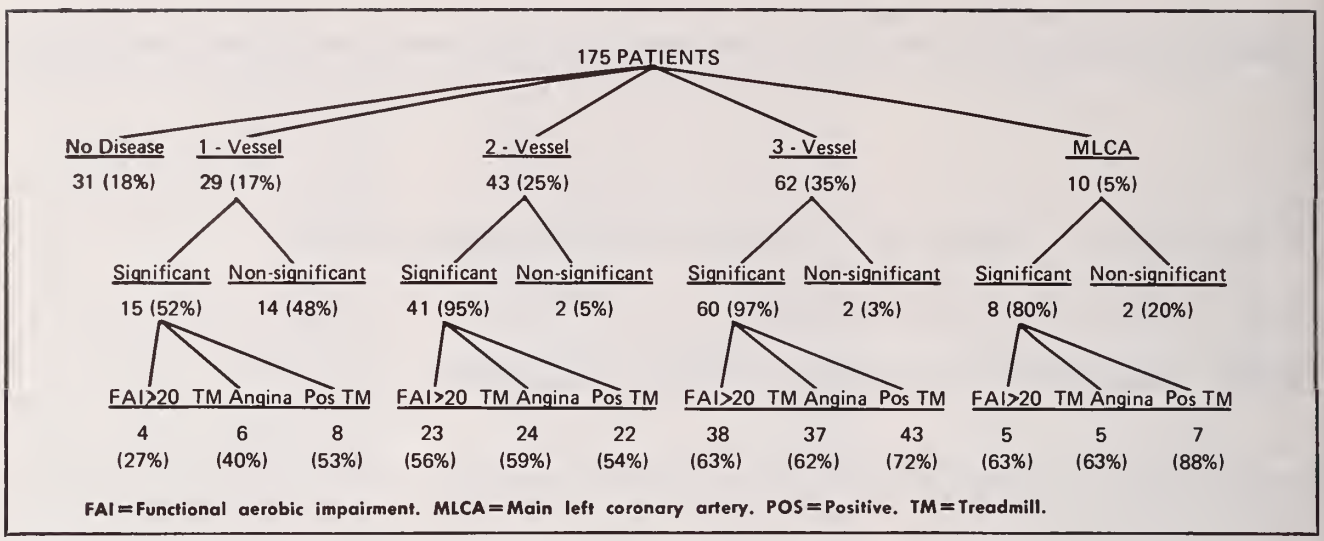

Figure 1—The total patient population divided into number of vessels involved, presence or absence of significant disease and maximal treadmill stress test results (functional aerobic impairment, angina, and maximal treadmill stress test electrocardiogram). Salient features are highlighted in the text.

clude the presence of significant coronary artery disease in cases of chest pain compatible with angina pectoris and chest pain of uncertain origin. It also was used to define the location and extent of coronary artery disease in young patients eight weeks post myocardial infarction prior to return to manual labor or vigorous activities.

Following a resting 12-lead electrocardiogram, a maximal treadmill stress test was attempted by the patient in the fasting state according to the Bruce protocol.[8] The end point goal of each test was a level of presumed maximal oxygen consumption (Vo_2 max). Individually determined end points of fatigue and shortness of breath or observed end points of ataxic gait, multiple premature ventricular contractions, or moderately severe angina pectoris also led to discontinuation of the test. The functional aerobic impairment or percent difference from Vo_2 max was derived from the appropriate Bruce nomogram.[9] Eighty-five patients (49%) did not reach the submaximal exercise level of 20% or less functional aerobic impairment for one or more of the above reasons. No attempt was made to separate these patients from the study population. To do so would eliminate patients with positive maximal treadmill stress test electrocardiograms and maximal treadmill stress test angina, and adversely affect the overall results in a catheterization population in one direction, just as eliminating patients with fatigue might adversely affect the results in the opposite direction. It is to be noted that only 15 patients with functional aerobic impairment greater than 20% had insignificant disease.

The three channel 12-lead electrocardiogram was monitored continuously throughout exercise and was recorded immediately, one minute, two minutes, four minutes, six minutes, and eight minutes following exercise. The postexercise electrocardiogram was observed for horizontal ST segment depression of 1 mm for at least 0.08 seconds by three cardiologists. Agreement in reading by two of the three interpreters determined the results of the test. The electrocardiogram was observed for ischemic change, without knowledge of the results of coronary arteriography.

Cardiac catheterization studies were carried out according to the Sones technique, and all physiologic hemodynamic measures were recorded prior to the contrast studies. Left ventriculography was carried out in two projections, and coronary arteriography in multiple projections.

Significant coronary artery disease was defined as 70% or greater narrowing of lumen diameter in the right coronary artery, left anterior descending coronary artery, and circumflex coronary artery. In the main left coronary artery, 50% or greater stenosis was considered significant. A 50% stenosis was utilized for determining the number of vessels involved.

Left ventricular function was evaluated by left ventricular end diastolic pressure, cardiac index, and left ventricular stroke work index. The visual interpretation of the left ventricular angiogram was described by the arteriographic radiologist. Ejection fractions and volume determinations were not available at the time of this study.

Results

The population consisted of 175 patients (150 men and 25 women) with an age range of 32-68 ($\overline{53.8}$). According to the criteria established, 31 patients (18%) had no disease identified and 144 patients (82%) had one, two, three vessel, or left main coronary artery disease with greater than 50% stenosis. Of the 144 patients with identifiable disease, 124 had significant coronary artery lesions (Fig 1).

Maximal treadmill stress test electrocardiographic results (Tables 2, 3): The *sensitivity* of the maximal treadmill stress test electrocardiogram in correctly identifying patients *with* coronary artery disease in this study was 64%. The *specificity* of the maximal treadmill stress test electrocardiogram in identifying patients correctly as *not* having coronary artery disease in this study was 60%. The *predictive accuracy* of the stress test electrocardiogram in *forecasting* the presence of coronary artery disease in this population was 80% (Table 3, Group A). The level of significant stenosis was increased to 90% of lumen diameter for comparison to the above results. This improved the sensitivity of the maximal treadmill stress test electrocardiogram to 77%, but decreased the specificity to 45% and the predictive accuracy to 68% (Table 3, Group B).

Left ventricular function: There were 27 patients with cardiac index less than 2.5 liters per minute per meter squared and 30 patients with a left ventricular stroke work index less than 40 grammeters per beat per meter squared and 16 patients with left ventricular end diastolic pressure greater than 16 mmHg. Twelve ventriculograms were graded as poor contraction or severe impairment of contraction. The patients with normal ventricles or only mild impairment of contraction were identified as a separate subgroup and compared to the entire population, which includes the poor ventricles. No obvious positive or negative effect on maximal treadmill stress test electrocardiogram results was noted relative to left ventricular performance (Table 3, Group C).

Resting nonspecific electrocardiographic changes or previous myocardial infarction by electrocardiogram: These factors might be expected to adversely affect maximal treadmill stress test results. The nonspecific resting changes actually enhanced the interpretive results of the stress test electrocardiogram. This may be due to closer scrutiny of these tracings by the interpreter, but may be only an unexplained variable. The presence of a previous myocardial infarction on the resting electrocardiogram might be expected to interfere with the inter-

Table 2—Clinical and maximal treadmill stress test correlations

Total population	175
Total significant disease	124 (71%)
Total insignificant disease	51 (29%)

Total patients each factor	*Factor*	*Significant disease*	*Insignificant disease*
70	Angina: Classical	61 (87%)	9 (13%)
65	Angina: Atypical	36 (55%)	29 (45%)
40	Angina: None	31 (78%)	9 (22%)
85	FAI % >20	70 (82%)	15 (18%)
87	Angina on treadmill	73 (84%)	14 (16%)
88	No angina on treadmill	50 (57%)	38 (43%)
75	Exercise ECG: Negative	45 (60%)	30 (40%)
100	Exercise ECG: Positive	80 (80%)	20 (20%)

ECG = Electrocardiogram. FAI = Functional aerobic impairment.

Table 3—Study population divided into subgroups

Group	*No. of Patients*	*FP*	*FN*	*Sensitivity*	*Specificity*	*Predictive Accuracy*	*Accuracy of Identification (TP + TN)*
A MTST ECG (Significant disease = 70% stenosis)	175	12%	26%	64%	60%	80%	63%
B MTST ECG (Significant disease = 90% stenosis)	175	22%	14%	77%	45%	68%	65%
C MTST ECG ("Normal" LV)	113	17%	21%	67%	54%	72%	62%
D MTST ECG (Resting ECG ST changes)	55	7%	16%	78%	71%	89%	76%
E MTST ECG (Prior MI on ECG)	79	11%	35%	57%	36%	80%	53%
F MTST ECG (Chest pain history)	135	10%	21%	70%	67%	84%	69%
G MTST Angina (Significant disease = 70% stenosis	175	8%	29%	59%	73%	84%	63%
H MTST Angina (Chest pain history)	135	9%	19%	74%	69%	86%	73%

ECG = Electrocardiogram. LV = Left ventricle. MI = Myocardial infarction. MTST = Maximal treadmill stress test. TN = True negative. TP = True positive. FP = False positive. FN = False negative.

pretation and adversely affect the results. Although this occurred in this population, no definite direct relationship can be inferred (Table 3, Groups D, E).

Maximal treadmill stress test angina response: The patients with insignificant disease who developed angina on the treadmill may have a false positive response to the maximal treadmill stress test, but they may also represent those patients whose angina is caused by pathophysiologic factors other than large vessel coronary disease. The patients with significant disease who did not develop angina on the treadmill probably represent a false negative response to stress testing. However, this group may also include patients who discontinued exercise prior to reaching an angina provoking level, as well as those who are ischemic nonangina producers and those who utilize or deliver oxygen more efficiently, even with high grade coronary stenosis (Table 3, Group G).

Maximal treadmill stress test electrocardiogram and maximal treadmill stress test angina—patients with chest pain: The elimination of the 40 patients without chest pain yielded a population of 135 patients with either classical angina pectoris or atypical chest pain. It is to be noted that in patients with chest pain the angina response to stress testing was almost identical to the electrocardiographic results obtained in the attempted maximal treadmill stress test (Table 3, Groups F, H).

Discussion

The present study correlates maximal treadmill stress test data with findings at catheterization and coronary arteriography in a large consecutive group of patients. The patient population obviously is highly selected and not comparable to populations of asymptomatic patients.

The results in this study and others suggest that correlation between classical angina pectoris and significant coronary artery disease is quite good, and the presence of either angina on the treadmill or a positive maximal treadmill stress test electrocardiogram correlates with the presence of significant disease in a lesser but equal proportion.[10-16] The same is not true for atypical chest pain, where significant disease is less likely, the presence of angina on the treadmill correlates less well, and the presence of a positive maximal treadmill stress test electrocardiogram correlates rather poorly.

Increasing the ST segment depression required to identify a positive stress test electrocardiogram to 2 mm or increasing the severity of significant stenosis to 90% of luminal diameter would achieve the desirable feature of eliminating false negatives from the population and increasing the sensitivity of the test. However, this does not increase the overall accuracy of identification, and it is highly likely that if the above were insisted upon, increasing infarctions and death would occur prior to medical or surgical intervention.

The functional aerobic impairment of greater than 20% in many cases was determined by the development of angina pectoris and may properly reflect the true functional aerobic impairment of the heart. The same presumption cannot be made for those subjects who stopped the study for other reasons. The patients with single vessel disease (73%) or normal left ventricles (90%) reached a functional aerobic impairment of less than 20% in a higher percentage than the total population (51%). This suggests that the greater the severity of coronary or ventricular disease the greater the impairment of exercise performance. As was noted in the RESULTS section, left ventricular performance did not affect maximal treadmill stress test electrocardiographic results.

In the presence of chest pain of a classical nature, there is no substitute for coronary arteriography to appropriately identify presence, extent, and severity of significant coronary disease. The presence of insignificant coronary artery disease in patients with "classical" chest pain should be similarly identified by coronary arteriography to avoid their being labeled as cardiac patients unnecessarily.

The sensitivity of a careful history for the diagnosis of coronary artery disease seems to be equal to or superior to the maximal treadmill stress test in patients with typical angina pectoris and in patients with pain clearly not angina pectoris.[17-19] In this study 61 of 70 patients (87%) had significant disease and classical angina pectoris. Of this number 50 patients (82%) developed angina pectoris on the treadmill. Forty of the 50 patients (80%) with significant disease, classical angina, and angina on the treadmill also had a positive maximal treadmill stress test electrocardiogram.

The relative sensitivity of the history and the treadmill stress test in defining significant coronary artery disease in those patients with classical angina pectoris is less important than trying to improve the sensitivity of testing for those with atypical chest pain.[20] This group should have tests with relatively good sensitivity and predictive accuracy to identify those patients with significant coronary artery disease. Because the frequency of significant coronary artery disease in patients with atypical chest pain is approximately 50% of that population, it appears that coronary arteriography is even more important in this group than in those with typical chest pain, not for identification of extent and location of coronary disease, but for the identification of its presence or absence.

The physician and cardiologist must realize the limitations of the history, resting electrocardiogram, maximal treadmill stress test electrocardiogram, and maximal treadmill stress test angina response individually and in combination. Physicians who evaluate patients with chest pain must be prepared to proceed to cardiac catheterization and coronary arteriography in the

best interests of those patients to identify the presence, absence, and extent of disease.

Conclusions

(1) Maximal treadmill stress testing is a useful adjunctive diagnostic procedure in the diagnosis of ischemic heart disease.

(2) Maximal treadmill stress test sensitivity in a population with a high prevalence of significant coronary artery disease can be affected by other factors in that population that are poorly resolved by subgrouping.

(3) Maximal treadmill stress test sensitivity and specificity alone are inadequate factors on which to base therapeutic judgments.

(4) There is presently no appropriate substitute for coronary arteriography to identify the presence or extent of coronary artery disease in patients with chest pain.

(5) The most appropriate therapeutic decision can be made on the basis of a careful history, appropriate adjunctive studies, and anatomical definition of disease by coronary arteriography.

ACKNOWLEDGMENT: The authors are indebted to Frederick J Wenzel, BS and Dean A Emanuel, MD of the Marshfield Clinic and Marshfield Clinic Foundation, Marshfield, Wisconsin, for their technical advice in the preparation of the manuscript.

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ABSTRACT/ WISCONSIN AUTHORS

Correlation of exposure to various respiratory pathogens with farmer's lung disease

JAMES J MARX JR, PhD; MARY ALICE KETTRICK-MARX, PhD; PAUL D MITCHILL, PhD; and DENNIS K FLAHERTY, PhD; Marshfield Medical Foundation, Inc and Marshfield Medical Center Laboratories, Marshfield; and the Allergy Section, University of Wisconsin, Madison, Wis: *J Allergy Clin Immunol* 60:169-173 (Sept) 1977

Three agricultural populations were tested for serologic reactivity to a panel of respiratory pathogens by the complement fixation test and compared to normals. The panel included *Mycoplasma pneumoniae*, Influenza viruses A and B, adenovirus, and respiratory syncytial virus. The populations were separated on the basis of the presence of precipitating antibodies to the thermophilic actinomycetes (TA) and a history of farmer's lung disease (FLD). Groups I and II consisted of farmers with antibodies to the TA, while groups III and IV had no demonstrable antibodies. Group I had a history of clinical FLD, group II had no evidence of FLD, group III were farmers without FLD, and group IV were normal non-farmers.

Farmers with precipitating antibody activity to one or more of the TA (groups I and II) regardless of past clinical history, demonstrated a greater frequency of complement fixing antibodies (CFA) to *M pneumoniae* and Parainfluenza virus types 1, 2, and 3 than those groups without antibody to the TA (groups III and IV). The results are summarized in Table 1. Even though the frequency of response in groups I and II was greater than groups III and IV, the levels of CFA were not higher in any of the positive subjects tested.

Immunoglobulin levels were also elevated in groups I and II when compared to the control groups. Unlike IgG and IgM, IgA was elevated only in the farmers who had a clinical history of FLD group I but not in farmers without such a clinical history (group II). The results suggest that farmers who develop FLD are exposed to a wider variety of pathogens than are other farmers but do not respond in an accelerated manner. ■

Epidemiology of burn injury in rural Wisconsin

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THE UNIVERSITY OF Wisconsin Burn Unit in Madison serves a large part of the rural area of the state with over three-fourths of admissions coming from outside the Madison area. The burn injuries seen, typical of those found in the state in general, are somewhat different from those found in heavy population, urban areas like Milwaukee. We reviewed our experience over the last three years with more than 200 patients, collating the source and type of injury with age and calendar distribution.

Calendar Distribution

We noted as shown in Figure 1 a large seasonal variation in burn admissions. The majority of burns occurred in the summer and early fall with a steady decline during the winter months. Our experience is similar to other Midwest, rurally placed burn units in Illinois and Minnesota, but different from dense population areas where large fires due to faulty heating equipment are common during the winter months.

Age distribution was shown on Figure 2 with the mean age being 23 years. Seventy-five percent of the patients were male.

Source of Injury

We found that the home remains the most dangerous place for potential burn injury. Sixty percent of burned patients were injured at home. Twenty-five percent of burns occurred at work. Auto accidents, camping mishaps, and miscellaneous situations accounted for the remaining 15%. When looking at the source of the burn, particularly in the home, we found several points of interest (Fig 3). First, scalding is a major source of burns and is clearly the most common burn cause in the infant to two-year-old group.[1] Second, the misuse of gasoline continues to be a major problem with no evidence of decreasing incidence. Explosions from gas utilities, stoves and furnaces also remain high on the list of burn sources. Injuries due to clothes catching fire are on the decrease in the toddler group, probably because of the treatment of sleepwear[2] with flame retardants. In all other age groups, the incidence of burns due to clothes afire does not appear to be decreasing.[1]

In work related injuries, gasoline is the most prominent single cause of burns accounting for 30% of such injuries. Other major sources of burns include chemicals and electricity. Although they occur infrequently, tractor related injuries

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Figure 1

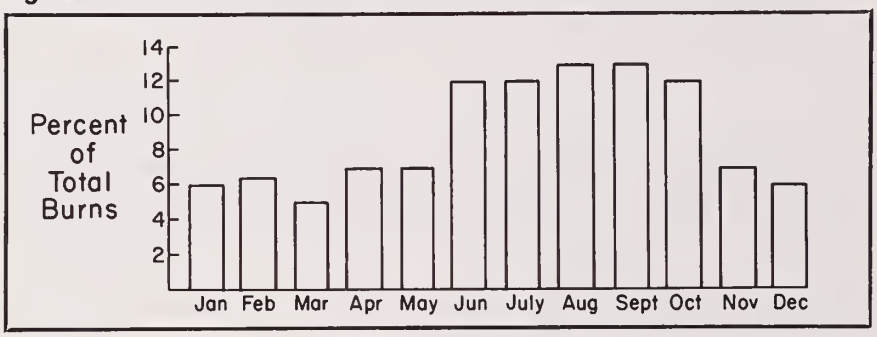


Figure 2

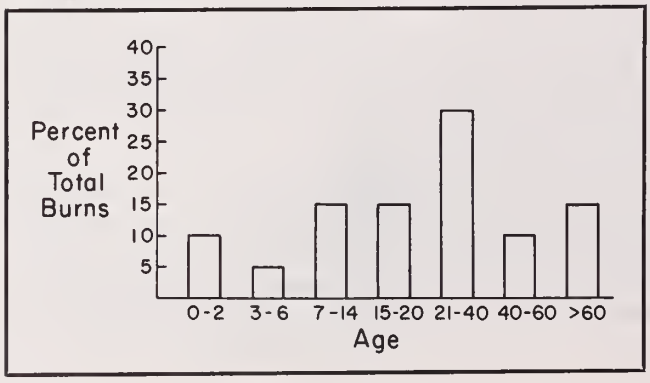
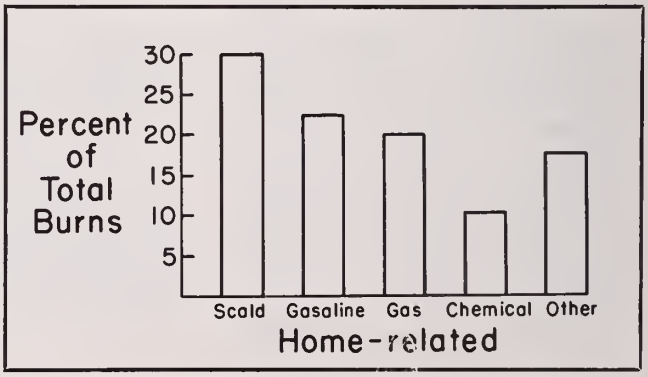


Figure 3



stand out as especially severe. We received three, nearly identical injuries last summer when tractors rolled over, pinned the driver beneath, and then caught fire. All these injuries were severe due to the prolonged exposure to fire, and superimposed fractures and tissue trauma. Tractor-related burn injuries have, interestingly, been confined to the age group below 20 and over 60 suggesting that faulty judgment may play a major role.

Two types of burn injury deserve further discussion because both are completely preventable. The first is scalding. As stated before, this is the most common burn of infants and toddlers. Although these injuries are not usually fatal, they often leave major, life-long scars on the face, neck and upper chest due to overturned pans of boiling liquid falling down onto the child. Bathtub scalds are less prevalent but still occur.

The second type of preventable burn is due to the careless use of gasoline. Invariably this injury produces third degree burns as clothes catch fire. The overwhelming majority of these are preventable with education in the hazards and potential devastating effects of gasoline fires. A one-gallon can of gasoline has the explosive force of 20 sticks of dynamite. Frequently the source of the fire is a hidden pilot light in the furnace, water heater or stove around which gasoline is being stored or used for cleaning purposes. Although difficult to understand, the combination of cigarette smoking and gasoline continues to be a common cause of major burns.

The patients presented are only a small sample of the 300,000 Americans burned each year. Fifty thousand of these require hospitalization. Although advances in burn care in recent years have dramatically reduced mortality from burns, permanent physical and psychological scarring still are unsolved problems. Recently, there has been an encouraging upsurge in interest shown by state and federal organizations in education programs and research on burn prevention. We hope these efforts will be successful in improving future statistics.

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PERINATOLOGY

Results of amniocentesis under ultrasound guidance

William Koller, MD, Madison, Wisconsin

DURING THE PAST SEVERAL years amniocentesis has become a common and valuable technique in the assessment of erythroblastosis, chromosomal and biochemical abnormalities, and pulmonary maturity. Although it is widely believed that amniocentesis under ultrasound is an innocuous procedure, there is enough opinion to the contrary to merit a review of available data.

The accompanying article outlines the **advantages and complications of amniocentesis** performed under ultrasound guidance.

THE USE OF amniocentesis for diagnostic and therapeutic purposes has increased since 1930 when it was first introduced. Most of the hazards associated with amniocentesis occur when it is used for therapeutic purposes such as induction of abortion, relief of hydramnios, or intrauterine transfusion. This can be expected in view of the traumatic nature of these procedures. However, there also may be risks associated with amniocentesis performed for diagnostic purposes. While in individual cases the chances of serious complication are small, with increasing number of diagnostic taps now being performed an increasing number of complications is likely to be encountered especially placental damage, fetal-maternal hemorrhage, and maternal sensitization. Also a bloody amniocentesis can interfere with the growth of fetal cells and culture and also can make diagnostic tests for Delta OD and L/S ratio unreliable or difficult to interpret.

Does ultrasound reduce the risk of a grossly bloody amniocentesis and the risk of fetal or maternal bleeding? It appears that the inci-

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dence of grossly bloody amniocentesis is unchanged in the third trimester by using ultrasound for localization of uterine contents.[1] However, there are benefits associated with the use of ultrasound, that is the avoidance of fetal injury, diagnosis of hydatidiform mole and neural tube defects, and a reduction in the number of attempts at amniocentesis. The use of ultrasound in the middle trimester reduces the incidence of grossly bloody amniocentesis.[1,2,3,6] In both trimesters the incidence of fetal injury and fetal bleeding is reduced by using ultrasound. It has been demonstrated that this benefit is only obtained if amniocentesis is performed at the time of ultrasound. A lag period of as little as three or four minutes is enough to negate any benefit derived by using ultrasound. The experience of the person doing the amniocentesis also affects the results. It has been found that if an amniocentesis is done by a physician trained in ultrasound and the procedure, bloody amniocentesis occurs 2% of the time.[6] Many studies have shown a reduction in microtransfusion of fetal blood to the maternal system by using ultrasound to aid amniocentesis.[2] Does microtransfusion pose a threat to the mother or the fetus? Antibody titers have been shown to increase by three or more tube dilutions in 20% of Rh negative mothers with Rh positive fetus following amniocentesis. However, the outcome of the pregnancy did not correlate with the antibody level rise. In fact, the outcome correlated better with prior antibody titers. This can possibly be explained by the short duration of exposure of the fetus to the antibody levels following amniocentesis. The outcome of the following pregnancy, however, is well correlated with these new antibody levels.[4]

Any time blood is obtained during amniocentesis a test to determine if it is maternal or fetal in origin is required. One of the most difficult problems to deal with is a fetal bleed following amniocentesis. The literature is scanty in regard to this, but the incidence appears to be approximately 2%.[5] The bleeding can result from puncture of fetal vessels on the placenta, the cord, or direct fetal injury. The most expeditious mode of delivery must be considered by the clinician when gestation is at or near term. If this occurs in early gestation, continuous monitoring may be helpful.

The use of ultrasound for placental localization has been recently reviewed at Madison General Hospital. There was a total of 437 patients for which there was sufficient information available. The patients underwent 561 attempts at amniocentesis. There were 131 bloody amniocenteses in these patients (23.3%). Of these 130 were maternal (23.2%), and one was fetal in origin (0.1%). There were 83 patients (19%) who required more than one attempt. The total number of attempts in this group was 197, or 2.4 attempts per patient. This group had 100 attempts (76%) that were bloody leaving only 31 bloody amniocenteses in the single attempt group. This means that if only one attempt is made, there is an 8.5% chance of a bloody amniocentesis occurring. The one fetal bleed in this group occurred during five attempts at amniocentesis. There were 76 amniocenteses attempted for genetic reasons, 12 or 15% of these were bloody taps and all were associated with more than one attempt.

Based on data from the literature and our own experience we may conclude the following:

1. Ultrasound localization of the placenta prior to amniocentesis decreases the number of bloody taps in mid-trimester pregnancies. It also decreases the number and amount of fetal maternal transfusion at all gestational ages and reduces the risk of fetal injury at all gestational ages.
2. Amniocentesis should be performed immediately after ultrasound to avoid the risk of fetal injury and/or dry amniocentesis.
3. Fetal maternal transfusion following amniocentesis doesn't seem to adversely affect the current pregnancy, but does affect the following pregnancy.
4. If fetal blood is obtained, immediate delivery is indicated if the fetus is mature; otherwise, monitoring may be beneficial.
5. Bloody amniocenteses are the result of multiple attempts. Ultrasound reduces the number of attempts per patient and may cause one not to do amniocentesis if the likelihood of success is poor.
6. Ultrasound should be used to map uterine contents as a guide to amniocentesis.

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Neurosurgical experience with carotid endarterectomy at University Hospitals (1954-1976)

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CEREBROVASCULAR DISEASE is the third leading cause of death in the United States. The majority of strokes involve the areas of the brain supplied by carotid arteries. Extracranial atheromatous plaques in the carotid play an important role in producing cerebral ischemia. Prior to 1950, transient ischemic attacks (TIA) were usually attributed to cerebrovascular spasm. In 1951 the first successful carotid reconstruction was performed by Carrea, Molins and Murphy[1] in Buenos Aires. Carotid endarterectomy was brought to the attention of vascular and neurological surgeons in 1954 by Eastcott, Pickering and Rob.[2] During 1953 and 1954 we did a number of carotid embolectomies and cervical sympathectomies at the University Hospitals and our first carotid endarterectomy in 1954.

Classification of Patients

We have classified our patients into three categories:

1. *TIA*—A circulatory episode with short-lived neurological deficit with complete recovery within 24 hours and completely negative neurological examination at the time of endarterectomy.

2. *Completed stroke*—A stabilized or improving condition with TIAs. The neurological deficit in this group ranged from mild to marked impairment.

3. *Progressive stroke*—A stroke in evolution usually due to acute occlusion of the carotid causing ischemic cerebrovascular disease with the patient's condition worsening rapidly. The majority of our patients in this category were operated upon during the 1950s and would not be considered surgical candidates today.

This presentation includes 138 endarterectomies performed on 128 patients between 1954 and 1976 (Table 1). All patients were Caucasian with an average age of 57.9 years. The youngest patient was 32 years old, the oldest 76 years old. The average age for the TIA group was 59.6 years; for the completed stroke group, 55.2 years; and for progressive stroke group 52.3 years. Two-thirds of the patients were less than 65 years old (Table 2). The ratio of male to female was three to one. Symptoms and signs at the time of admission to the hospital are presented in Table 3. The incidence of bruit over the carotid bifurcation in the neck is given in Table 4. The incidence of precipitating or associated factors, hypertension, cardiac disease, family history, obesity, diabetes, smoking, or other vascular disease is presented in Table 5.

We have performed no endarterectomy for an asymptomatic bruit.

Diagnostic Studies

Electroencephalogram with or without carotid compression, ophthalmodynamometry (Table 6) and radioisotope brain scan have been employed in the majority of patients. Skull x-ray studies have been used routinely. In recent years Doppler studies and computerized axial tomography (CAT) have been performed. Arteriography was done by percutaneous puncture of the carotids during the 1950s. Subsequently, we employed three- or four-vessel studies by percutaneous retrograde brachial or axillary routes. During the past ten years a retrograde catheter transfemoral technique has been employed almost routinely to visualize the aortic arch, carotids, and vertebrals.

Table 1—CAROTID ENDARTERECTOMY (138 procedures)
Classification of patients

	Total	*Male*	*Female*	BILATERAL ENDART. *Male*	BILATERAL ENDART. *Female*
Transient ischemic attack (TIA)	88	65	23	7	2
Completed TIA	23	18	5	1	0
Progressive	17	14	3	0	0
TOTAL	128	97	31	8	2

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Presented at the Annual Meeting of the Wisconsin Neurosurgical Society, Green Bay, October 1977.

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Technique of Endarterectomy

Local anesthesia was used in all patients during the early years. In the late 1950s we began using continuous EEG monitoring with the patient under general anesthesia. For the past 15 years we have performed the majority of the operations under general anesthesia with routine EEG monitoring and with almost routine insertion of an internal shunt (Table 7) and systemic heparinization routinely at the time of endarterectomy. In some patients we have measured carotid stump pressure to investigate the adequacy of cerebral circulation. In recent years, we have kept the patient's blood pressure 20 to 30 mmHg above levels that are normal for the patient routinely during the procedure.

Carotid endarterectomy of the occluded vessel was performed in 27 patients, endarterectomy on the opposite carotid in 13 patients and external carotid endarterectomy in 2 patients (Table 8).

Results

Operative deaths and permanent neurological complications are presented in Table 9, and the cause

Table 2—Carotid endarterectomy (128 patients)
Age distribution

No. of patients	*Under 65*	*65 or Older*
Transient ischemic attack (TIA)	62	26
Completed	18	5
Progressive	12	5
TOTAL	92	36

Table 3—Carotid endarterectomy (128) patients

Symptoms and signs	*No. of patients*
Hemiparesis	55
Hemianesthesia	38
Amaurosis fugax	37
Dysphasia	28
Dizziness	27
Monoparesis	27
Dysarthria	19
Syncope	16
Headache	13
Hemianopsia	13
Confusion	8
Seizures	6
Diplopia	3

Table 4—Carotid endarterectomy

	NO. OF PATIENTS	
	Bruit	*No Bruit*
Transient ischemic attack	51	37
Completed	6	17
Progressive	6	11
TOTAL	63	65

Table 5—Precipitating or associated factors

	Total	*Hypertension, cardiac disease*	*Family history*	*Obesity*	*Diabetes*	*Smoking*	*Other vascular disease*
Transient ischemic attack	88	56	59	28	9	41	4
Completed	23	12	12	5	2	9	6
Progressive	17	7	9	7	1	7	0
TOTAL	128	75	80	40	12	57	10

Table 6—Ophthalmodynamometry

		Positive	*Negative*
Transient ischemic attack	64	40	24
Completed	11	8	3
Progressive	6	6	0
TOTAL	81	54(66.6%)	27(33.3%)

Table 7—Carotid endarterectomy

	SHUNT		EEG		ANESTHESIA	
	Yes	*No*	*Yes*	*No*	*Local*	*General*
Transient ischemic attack	59	38	62	35	20	77
Completed	7	17	7	17	11	13
Progressive	5	12	4	13	5	12
TOTAL	71	67	73	65	36	102

Table 8—CAROTID ENDARTERECTOMY: Complete carotid occlusion

	Endarterectomy Occluded vessel	*Endarterectomy Opposite side*	*Internal carotid occlusion; External carotid endarterectomy*
Transient ischemic attack	8	9	1
Completed	10	3	1
Progressive	9	1	0
TOTAL	27	13	2

Table 9—Operative deaths and permanent neurological complications

	Procedures	*Death*	*Complications*
Transient ischemic attack	97	1 (1.03%)	4 (4.1%)
Completed	24	4 (16.6%)	2 (8.6%)
Progressive	17	7 (41%)	3 (17.6%)
TOTAL	138	12 (8.6%)	9 (6.5%)

Table 10—Cause of death (operative mortality)

		Cerebral Infarction	*Cardiopulmonary*	*Procedures*
Transient ischemic attack	1	0	1	97
Completed	4	2	2	24
Progressive	7	4	3	17
TOTAL	12	6	6	138

Table 11—Operative deaths (cerebral) (6 Patients)

	EEG (73 Pts)	*No EEG (65 Pts)*	*Shunt (71 Pts)*	*No Shunt (66 Pts)*
Transient ischemic attack	0	0	0	0
Completed	0	2	0	2
Progressive	0	4	1	3
TOTAL	0	6	1	5

Table 12—CAROTID ENDARTERECTOMY: Neurological complications (14 patients)

	Total	*Transient*	*Permanent*
Transient ischemic attack	7	3	4
Completed	3	1	2
Progressive	4	1	3
TOTAL	14	5	9

Table 13—CAROTID ENDARTERECTOMY: Nonneurological complications (successfully treated—5 patients)

	Cardiac	*Respiratory*
Transient ischemic attack	2	1
Completed	0	0
Progressive	0	2
TOTAL	2	3

Table 14—CAROTID ENDARTERECTOMY: Follow-up

	Total	*Dead*	*Average Survival (yrs) (Average + S.E. before death)*	*Longest follow-up (yrs)*
Transient ischemic attack	88	27	4.3 ± 0.8	16
Completed	23	12	5.1 ± 1.5	22
Progressive	17	13	1.5 ± 0.8	9
TOTAL	128	52		

Table 15—CAROTID ENDARTERECTOMY: No postoperative complications; long-term follow-up

	Total	*Doing well or stable*	*Living recurrent TIA or stroke*	*Death*
Transient ischemic attack (TIA)	77	53 (68.8%)	3 (4%)	21 (27.2%)
Completed	16	9	0	7
Progressive	4	3	0	1
TOTAL	97	65	3	29

of death in Table 10. There were no cerebral deaths in patients with TIA or among the 73 patients in the TIA, completed or progressive stroke groups on whom continous EEG monitoring was carried out (Table 11). Neurological complications are presented in Table 12 and non-neurological complications—cardiac or respiratory—are shown in Table 13. Long-term follow-up results are listed in Table 14 and the follow-up of patients with and without postoperative complications in Tables 15, 16, 17 and 18.

Conclusion

Based on our experience with carotid endarterectomy during the past 22 years, we feel it is a valuable procedure in the management of transient ischemic attacks, especially for a single stenotic lesion of the carotid.

Patients with a mild completed stroke who have minimal, residual neurological deficit or those with old strokes who develop new TIAs should be seriously considered for surgery providing their condition is stable and their brain or CAT scan has returned to normal. In our experience, this usually takes four to six weeks following a TIA.

The patients with stroke in evolution are not candidates for surgery. Since the operative mortality and morbidity is extremely high for these patients, they should be treated medically.

Patients with chronic complete occlusion of the internal carotid are not candidates for surgery of the occluded side, unless the patient has marked stenosis of the external carotid artery with sufficient flow via collaterals. In these patients external carotid endarterectomy should be done before considering a bypass procedure. Another indication for surgery in patients with complete internal carotid occlusion is significant stenosis of the opposite carotid causing TIAs.

Although the majority of our patients had carotid stenosis of at least 75%, in recent years we have done endarterectomy for TIAs due to ulcerated plaques with a lesser degree of stenosis in the hope of

Table 16—CAROTID ENDARTERECTOMY: Long-term cause of death (patients without postoperative complications)

	Total	Stroke	Cardio. pul.	Compl. from other ops.	Cancer	Car accident	Unknown No P.M.
Transient ischemic attack	21	4	4	4	3	1	5
Completed	7	4	1	0	0	0	2
Progressive	1	0	0	0	0	0	1
TOTAL	29	8	5	4	3	1	8

Table 17—CAROTID ENDARTERECTOMY: Postoperative complications, long-term follow-up

	Total	Doing well or stable	Recurrent TIA and stroke	Death
Transient ischemic attack (TIA)	10	4	1	5
Completed	3	2	0	1
Progressive	6	1	0	5
TOTAL	19	7	1	11

Table 18—CAROTID ENDARTERECTOMY: Long-term cause of death (patients with postoperative complications)

	Total	Cardio. pul.	Cancer	Car accident	Abdominal embolism	Uremia	Unknown pos. stroke
Transient ischemic attack	5	3	0	0	1	0	1
Completed	1	0	0	0	0	1	0
Progressive	5	0	1	1	0	0	3
TOTAL	11	3	1	1	1	1	4

removing the source of microemboli in the cerebral circulation or retina.

In the evaluation of patients for endarterectomy, assessment of collateral circulation is essential. We believe that a combination of general anesthesia, continuous EEG monitoring, induced hypertension, and an internal shunt provides significant brain protection during carotid endarterectomy.

ACKNOWLEDGMENT: The authors gratefully acknowledge the assistance of Daria D Javid in gathering the data for this report.

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ABSTRACT/WISCONSIN AUTHORS

Bipedal lymphangiography in malignancies of the uterine corpus

MICHAEL T KADEMIAN, MD, DOLORES A BUCHLER, MD; and GEORGE W WIRTANEN, MD, University of Wisconsin, Madison, Wis: *Am J Roentgenol* 129:903-906, 1977

Bipedal lymphangiography was used to evaluate malignancies of the uterine corpus in 116 patients. Most of the cancers were adenocarcinoma (104) and the rest were sarcomas of various types. Of the 116 lymphangiograms, 32 were interpreted as positive for nodal metastatic disease, and 84 were interpreted as negative. Although histologic confirmation of nodal interpretation was seldom obtained, short-term follow-up indicates that a positive interpretation is associated with extremely poor prognosis. Forty-eight patients with Stage I disease underwent lymphangiography. Six patients in this group had positive findings on the initial examination; four have died from metastatic disease, the two other patients are alive at 12 and 24 months, respectively. By contrast, only 6 of 42 patients with negative lymphograms have died from disease. Similar results were seen in Stage II. Two of three patients with positive studies have died of disease in this group, whereas no patient with Stage II disease in which the lymphogram was interpreted as negative have died from disease. In Stage III, eight of nine patients with positive interpretation have died of malignancy, whereas only 6 of 16 patients with negative studies have died of disease. This procedure was employed in 10 patients with Stage IV disease, generally to help define radiotherapy portals. An additional eight patients had lymphograms as part of a workup for evaluation of possible recurrent disease and not at the time of initial staging. Followup in patients ranged from three months to six years. Based on the results of this study, bipedal lymphangiography is recommended for all Stage I patients except those with well-differentiated histology, a small corpus, and no deep myometrial invasion, all Stage II and III patients, and selected patients with Stage IV disease. This procedure also can be used to evaluate possible recurrent disease.—DOROTHY J BUCHANAN-DAVIDSON, PhD ■

The rheumatic disease problem

Series of six articles coordinated by **Gerson C Bernhard, MD,** Milwaukee, Wisconsin

If one considers the volume of patients who have rheumatic diseases and the great variety of rheumatic disorders, it is immediately apparent that this makes up a very important part of medicine for any primary care physician, especially those who care for adults. We now recognize almost 100 different types of arthritic, rheumatic, connective tissue diseases, or other disorders with a significant rheumatic component. Recent surveys in the United States estimate that there are 31 million people who have sufficient rheumatic problems to seek medical attention. Of these, about 250,000 are children below the age of sixteen. On the basis of population, we can estimate that there must be at least 600,000 people who fall into this category in the state of Wisconsin.

Scientific knowledge has burgeoned in the past two decades in the area of rheumatology. Most specifically, information regarding immunology, our understanding of the inflammatory response, information about cartilage metabolism, and genetics relating to disease susceptibility have been the areas of greatest stride. Sophisticated diagnostic techniques in radiology, immunology and synovial fluid studies have been developed, are of clinical value and are generally available. Every physician is aware of the simultaneous pharmacologic explosion which has resulted in a large number of new anti-rheumatic drugs as well as uric acid-controlling agents. New information has also been developed about the efficacy, toxicity and mechanism of action of old drugs such as aspirin and gold.

For these reasons, the rheumatologists of the Medical and Scientific Committee of the Wisconsin Arthritis Foundation agreed that there was a need to briefly review some of the current knowledge in a variety of topics that have direct practical value to general physicians. It is the primary care physician who first sees and treats the vast majority of patients with rheumatic problems. Only a small percentage of these patients has in the past been referred to rheumatology specialists. Six brief summary-type articles follow which discuss different rheumatologic topics. We hope that these are directly useful to you in the care of your patients.

—GERSON C BERNHARD, MD

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1. The use of thermic modalities in rheumatic diseases

Basilio Lopez, MD, Milwaukee, Wisconsin

THE USE OF thermic modalities is basic in treatment of arthritic conditions to facilitate the control of pain and to prevent or minimize some of the consequences of inflammation such as: swelling, stiffness, contractures, and muscle spasm. They allow the patient to exercise with less discomfort; their application improves local and general rest.

Since many of the effects of heat are similar to those of inflammation, in acute conditions the use of cold and superficial heat modalities are beneficial; deep heat should be avoided. Continuity of the therapy program can be maintained by introducing patients to appropriate modalities and training them in a home program.

Most physiological changes of heat and cold modalities are temperature related. Heat modifies the pre-existent gradients. Normal temperature values are: skin 33 to 36C, subcutaneous tissue 36 to 36.6C, muscles 37.6C and joints 30.5 to 33C.

Cardiovascular reactions include the changes in the blood flow and its distribution, and the increase of cardiac rate above the resting values, usually 10 beats per 1 degree Farenheit elevation (0.37C). There also is an increase of pulmonary ventilation, local vasodilation, and reflex actions with vasoconstriction of the mucosa and joints.

The changes on the peripheral and central nervous system are manifested by the general relaxation of the patient, increase of the pain threshold, and better tolerance to exercise. Some of these changes are inferred and supported by the hypothesis of the "gate" theory. The cortex, the hypothalamus, and the reticulospinal tract have heat-dependent reactions. These changes all must combine to produce a reduction of pain, and in addition there is a placebo effect.

The rheological properties of the tissues are modified by heat. The collagen tissue at normal temperatures has mostly elastic properties. With the increase of temperature, the elasticity diminishes and the viscosity increases with a tension drop.

Collagenolysis increases four times at 36C; heat also increases the production of hyaluronic acid and the lactic acid, the consumption of glucose, and it decreases the pH. One of the results is to lower the cartilage capacity to resist deformation. There also is an increase of diffusion.

Heat can be delivered by conduction, radiation, and conversion. Each of these produce specific effects and have indications and contraindications. For effective use heat must be prescribed with knowledge of local pathology, for a specific purpose, and with awareness of possible side effects, as when prescribing drugs.

The indications can be inferred by physiological changes due to heat. Contraindications are: degree of the inflammatory response, coagulation defects, hemorrhage, some infections. The growing epiphysis, the eyes, and the pregnant uterus should not be exposed to deep heat. The presence of normal sensation and an alert patient are important to avoid burns, as we lack the capacity to measure heat absorption.

Some of the more common heat modalities are: electric heating pads, hot water bottle, hydrocollator packs, paraffin, Hubbard tank, whirlpool, hot tubs, infrared, short wave diathermy, microwave, and ultrasound. Each modality has some specific contraindications.

Cold is a greater penetrant than heat. The blood flow alternates between vasoconstriction and vasodilatation. Cold decreases the blood flow, local edema, local muscle spasm, and spasticity.

Most of the changes can be achieved in five to ten minutes. Cardiovascular reactions are the increase of conduction time and blood pressure elevation which can preclude the use of cold. Cryoglobulenemia, paroximal cold hemoglobinuria, Raynaud's disease and cold allergy are other limitations to the use of cold. A trial with ice locally should precede the application of cold.

Acute inflammatory processes, the presence of edema, the acute muscle spasm, and the post-traumatic or post-surgical pain are the main indications for using cold modalities.

EDITOR'S NOTE: A photocopy of the bibliography is available upon request to the Journal. ■

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NEWS NOTE

PCBs not a worry for most nursing mothers: AAP

Exposure to PCBs (polychlorinated biphenyls) should almost never interfere with breastfeeding, according to the American Academy of Pediatrics' Committee on Environmental Hazards. The Committee statement appeared in a recent issue of NEWS AND COMMENT, the Academy's monthly news and feature publication.

"Unless women have a history of exposure to PCBs, they should be encouraged to breastfeed their infants as usual," said the Committee. "There are no known effects in children at levels found in people in the United States," they added.

"In the absence of evidence of harm to infants from the present levels of PCBs in breast milk, no change is recommended in current nursing practice," said Committee chairman, Robert W Miller, MD. ■

2. Treatment of rheumatoid arthritis with gold

George C Liang, MD, LaCrosse, Wisconsin

THE EFFICACY OF gold salts in the treatment of rheumatoid arthritis has been well established by several double-blind control studies.[1] Gold can induce remission and retard the destruction of bone and cartilage.[2]

Gold works best in the early stage of rheumatoid arthritis. It cannot undo irreversible damages, such as erosions, deformities, subluxations, or ankyloses. Gold therapy is recommended for established rheumatoid patients with unremitting or progressive synovitis in spite of adequate conservative therapy. Gold is not indicated either in those patients in the burned-out stage without active synovitis or in patients with impaired liver or kidney functions, blood dyscrasias, or histories of heavy metal toxicity. It is effective in about 60 to 70% of the patients with active disease. The remainder will develop gold toxicity or experience no response at all. Fatal reactions are unheard of in experienced hands.

There are two forms of gold salts available: gold sodium thiomalate (Myochrysine®) and gold thioglucose (Solganal®). Both forms are administered intramuscularly in one of the gluteal muscles at weekly intervals. One starts with a trial dose of 10 mg, then increases the dose to 20 mg, 30 mg, 40 mg, 50 mg at subsequent weeks if well tolerated. Pediatric patients receive an initial dose of 0.1 to 0.2 mg per kg per week, and this is gradually increased to 1 mg per kg per week. Patients are asked every week about the occurrence of metallic taste, itching, skin rash, mouth sores, diarrhea, or any unusual reactions. White blood cell count, hematocrit, platelet estimation on smear, eosinophil count, and urinalysis are performed weekly or biweekly. It is important to remain flexible in dosage according to each individual's response. Sometimes gold has to be given in smaller quantities or at lengthened intervals because of minor reactions or unusual sensitivity of the patient. Clinical improvement may begin around a cumulative dose of 300 to 500 mg. The weekly injections can be continued for several weeks to approximately 1000 to 1200 mg; then the interval between injections is lengthened first to every two weeks for two to four months, then similarly to three, four and six weeks. It takes about a year or less to obtain full therapeutic response, and the patient will eventually be maintained on one gold injection every three to six weeks for several years or the rest of his life. If the patient's arthritis flares up with prolonged intervals, they can be shortened again. If there is no clinical improvement after weekly dosage accumulating to 1.0 gm, gold should be discontinued.

Initially some patients experience arthritis or arthralgia that disappears with continuous gold therapy. A nitritoid reaction—an episode of flushing, diaphoresis, headache, and faintness that follows immediately after gold injection—is best handled by switching to the other preparation of gold salt. The most frequent toxic manifestation is a mild mucocutaneous lesion, either in the form of dermatitis or stomatitis.[3] The spectrum of gold dermatitis ranges widely from mild pruritus, erythema, morbilliform rash, licheniform eruptions to exfoliative dermatitis. A gold dermatitis may appear anytime, but most frequently it begins about the same time that the patient has slight clinical response to gold. It is usually pruritic and may be accompanied by eosinophilia. Mild skin rash and pruritus may disappear in a few days without treatment. If needed, anti-pruritic or topical steroid preparations can be prescribed. Hydroxyzine is useful for relief of itching. Prednisone, 10 to 15 mg a day for several weeks, is effective in controlling moderate to severe dermatitis. Mouth lesions can be treated with alkaline rinses or Xylocaine® 2% (lidocaine) HCl Viscous in severe cases. Minor degrees of pruritus, dermatitis, stomatitis, leukopenia, diarrhea, increasing eosinophilia, or intolerable metallic taste dictate reduction of the gold dosage to half or less. Moderate reactions require that gold be withheld until the condition clears and then reinstituted with much lower dosage if desirable.[4] Traces of proteinuria can be ignored. Heavy proteinuria (2+ or more), widespread skin eruptions, severe leukopenia, thrombocytopenia, and profuse diarrhea require cessation of gold therapy. These reactions usually remit after a few weeks or months. Exfoliative dermatitis is best managed in the hospital. Aplastic anemia, severe enterocolitis[5] and hepatitis also have been reported, but very rarely. Large doses of corticosteroid, dimercaprol (BAL) or penicillamine can be used in desperate situations, but such heroic measures are rarely required.

Clinical improvement is judged by the patient's own subjective feeling, diminution of morning stiffness, increase in grip strength, greater ease in movement, increase in functional capacity, decrease in the number of swollen and tender joints, decrease in the size of rheumatoid nodules. The erythrocyte sedimentation rate, hemoglobin, or hematocrit slowly improve. Leukopenia also may improve.[6] In some patients the rheumatoid factor titers are diminished.

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3. Spondylo-arthritis and the histocompatibility antigens

Franklin Kozin, MD, Milwaukee, Wisconsin

REMARKABLE PROGRESS has been made recently in our understanding of the spondylo-arthritides, a group of diseases characterized principally by inflammation of synovial joints of the axial skeleton (the apophyseal and sacro-iliac joints). These diseases, which include ankylosing spondylitis, Reiter's syndrome, and the arthropathies of psoriasis and inflammatory bowel disease, are sero-negative (rheumatoid factor) and frequently associated with mucocutaneous lesions, uveitis, gastroenteritis, urethritis, and an asymmetrical peripheral arthritis primarily in the larger joints. The overlapping clinical manifestations within this group have long suggested a common factor underlying their etiology and/or pathogenesis.

This common factor has now been discovered in the histocompatibility antigen—or HL-A—system. These antigens, which are highly specific determinants on the surface of all nucleated cells, are controlled by a cluster of genes on autosomal chromosome C6 in humans. They are instrumental in initiating the homograft rejection reaction so important in organ transplantation. It is possible to determine the HL-A type of patients by simple immunologic studies of circulating lymphocytes.

The HL-A-B27 antigen has been clearly associated with the spondylo-arthritides. First reported by Schlosstein[1] and Brewerton[2] and their co-workers in 1973, this finding has been confirmed and extended by a number of investigators since then. HL-A-B27 normally is found in approximately 8% of American whites and 4% of American blacks; in ankylosing spondylitis and Reiter's syndrome, the incidence of HL-A-B27 is 90 to 95%. A slightly lesser percentage (50-70%) of patients with psoriatic or enteropathic arthritis also possess this antigen. Other diseases associated with an increased incidence of HL-A-B27 include Yersinia-associated arthritis, sero-negative juvenile rheumatoid arthritis, and chronic anterior uveitis—each of which bears certain similarities to the classic spondylo-arthritides. From these observations it can be predicted that the incidence of spondylo-arthritis in a random group of HL-A-B27 positive persons would be increased. This is exactly what Cohen et al[3] reported in their studies of potential tissue donors in whom HL-A types were available. Remarkably, stigmata of spondylo-arthritis were present in 25% of such individuals.

How susceptible patients and the occurrence of spondylo-arthritis are linked by this genetic marker remains the subject of speculation. The most attractive hypothesis is based upon studies in mice where an immune response (Ir) gene has been identified within the HL-A system. It is thought that the HL-A-B27 locus is closely associated with specific abnormalities in the Ir gene that prevent appropriate immunologic reaction to a variety of environmental agents. A second intriguing hypothesis—the shared antigenicity theory—holds that antigens of foreign agents (bacteria, viruses) are structurally identical to certain cell surface antigens (*ie,* HL-A-B27), thereby interfering with the host's ability to recognize and mount an immunologic attack against this foreign antigen.

The practical importance of HL-A typing may exceed these theoretical considerations, as the presence of HL-A-B27 can be an important laboratory aid in differential diagnosis. Although the characteristic joint distribution and synovial fluid changes may suggest a spondylo-arthritic syndrome to an experienced observer, confident diagnosis may prove difficult in early or incomplete cases. In such instances, the presence of HL-A-B27 may be extremely helpful in establishing the diagnosis. It should be noted, however, that specific clinical features are necessary to distinguish various entities within the spondylo-arthritic group. HL-A typing also may be used for differentiating acute Reiter's syndrome from gonococcal arthritis. Finally, HL-A typing may prove useful in family (genetic) counseling and in predicting which persons are at risk for spondylo-arthritis.

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4. Osteoporosis and current therapy

Mark N Mueller, MD, Madison, Wisconsin

THE RESULT OF inadequate skeletal mass is pathologic fracture due to osteopenia (osteoporosis, osteomalacia, or both). The etiology of most osteopenia is obscure.

At birth bones are small, but with maturity the organic matrix and mineral content of bone increase, plateau, and then decline with advancing age. Women have smaller skeletons, lose bone earlier at a more rapid rate than men. Clinical osteoporosis is more commonly observed in women. Over 150,000 femoral neck fractures occur each year in the United States and more than 90% involve women. Such fractures occur after substantial bone loss has already occurred. Therapy for osteopenia is less than satisfactory, and a better approach would be to detect individuals at risk or who are beginning to lose a bone *before* fractures occur.

Identifying osteoporosis: More than 30% of skeletal mass is lost before osteopenia can be detected by x-ray. Bone biopsy and calcium balance studies are expensive, time-consuming, and not applicable to usual clinical practice. A rapid, safe, sensitive and inexpensive means of assessing bone mass is needed. Quantitative bone mineral analysis most nearly meets these requirements, and not only can identify individuals with skeletal demineralization but also can measure response to attempted therapy.

Etiologies of osteoporosis: Most osteopenia has no detectable cause, and the decreased skeletal mass is often referred to as "idiopathic" osteoporosis, or the osteoporosis of aging. Nonetheless, search for a treatable cause may be rewarding. Important considerations would include nutritional deficiencies, endocrine disease, neoplasm, alterations in physical activity, and certain drug-induced abnormalities.

Management of osteoporosis: The most urgent concern involves management of acute pathologic fractures. New orthopedic surgical approaches, especially to hip fractures, have improved the outlook for patients. With vertebral crush fractures or rib fractures the problem is management of pain, provision for healing, and remobilization of the patient.

The use of analgesics, occasionally splints, braces, or binders, and bed rest help control pain. Ordinary physical activity, such as sitting, standing or walking, does *not* increase the risk for subsequent fractures; bed rest and restricted activity should continue only until the acute pain and reflex muscle spasm are controlled. Braces may be useful acutely, but should not be used indefinitely since they allow atrophy of normal axial supporting structures.

Some medications are promoted as "muscle relaxants." In the usual doses, they do *not* relax muscles, but as sedatives may keep the patient at rest in the immediate post-fracture period. Once the acute phase is past, the patient should engage in graded exercise programs and perform muscle toning maneuvers, such as William's exercises (physical therapy can be helpful here).

Long-term management of osteopenia: Osteopenia results from bone resorption (osteoclast action) in excess of bone formation. Can measures be prescribed to prevent further bone loss or perhaps increase bone mass and strength? The answer is not clear. Bone resorption may be slowed. If optimum conditions can be maintained to provide for normal bone formation, increases of skeletal mass may result. However, homeostatic mechanisms work to "correct" slowed bone resorption. A drug which reduces osteoclast efficiency causes a decline in concentration of ionized calcium in the blood, leading to secondary hyperparathyroidism which again stimulates osteoclasts.

Drug therapy: A. *Estrogens*: Accelerated bone loss in castrated or post-menopausal women is related to estrogen deficiency. Estrogens can temporarily reverse negative calcium balance. Replacing estrogens inhibits the stimulatory effects of parathyroid hormone on osteoclasts, and may prevent further accelerated demineralization, but osteopenia *cannot* be reversed by estrogens. The question of risks associated with giving replacement estrogens is one of current controversy.

B. *Calcium and vitamin D supplements*: The dietary intake of calcium and vitamin D for most people declines with age. Whether this affects skeletal demineralization is uncertain. Attempts have been made to treat osteopenia with supplemental vitamin D and calcium, but no clear benefits have been observed. However, calcium and vitamin D are important in multicomponent drug therapy.

C. *Anabolic agents/androgens*: There is no acceptable evidence that these agents are useful in treating osteopenia.

D. *Combination therapy, including drugs that actively inhibit bone resorption*: Some drugs actively inhibit bone resorption. Calcitonin has a hypocalcemic effect due to inhibitory action on bone resorption. Calcitonin alone has no value in treating osteoporosis, but the use of calcium and vitamin D supplements along with calcitonin may result in long-term stabilization or increase in bone. At present, however, calcitonin is approved only for therapy of Paget's disease of bone.

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Fluorides in subtoxic doses lead to deposition of fluoroapatite crystals on the matrix of bone, making it more resistant to resorption. Calcium and vitamin D are given to suppress the parathyroid glands. This may ultimately lead to bone accretion. No proof of efficacy exists, but studies are continuing. Although this combination therapy is safe and inexpensive, medical supervision is necessary to avoid the rare but possible development of hypercalcemia in some individuals. The recommended doses are as follows:

a) NaF, approximately 50 mg daily (available as 2.2 mg tablets, 6-7 tablets three times a day).
b) Calcium, 1 gm elemental calcium daily (calcium carbonate 600 mg four times a day or calcium gluconate 10 gm daily).
c) Vitamin D (cholecalciferol), 50,000-unit capsule twice a week—*not* twice a day.

Recommended doses may have to be modified for individual patients.

Summary: Once osteoporosis is recognized and contributing factors investigated and treated, the following measures offer a reasonable opportunity for long-term stabilization of the skeleton or possibly even increased bone mass and strength:

1) Physical exercise.
2) Supplemental estrogens in the estrogen deficient woman (unless otherwise contraindicated).
3) Combination therapy with sodium fluoride, calcium, and vitamin D under careful medical supervision. ■

5. Correction of deformities of the fingers in rheumatoid arthritis

Donald M Levy, MD, Milwaukee, Wisconsin

About 75 percent of patients with rheumatoid arthritis develop involvement of the tendons and joints of the hand. In attempting to control the course of rheumatoid arthritis, an effort is made to prevent deformities of the hands by appropriate medical therapy and protection of the various joints. However, many patients already have advanced deformities when they are first seen by the rheumatologist and others may develop deformities in spite of the best medical management and physical therapy measures.

In the hands the initial changes of synovial proliferation and swelling may rapidly progress to joint degeneration and subluxation with a resultant severe loss of function. Improved surgical techniques and a fuller understanding of the pathologic processes of rheumatoid disease have afforded the hand surgeon the opportunity to alleviate pain, prevent or lessen deformity, and increase function in the crippled hands, so characteristic of rheumatoid arthritis. Although surgery cannot cure the systemic disease, it can arrest the disease in the operated joints for prolonged periods.

In rheumatoid arthritis the joint spaces become distended by thick mucinous fluid and proliferative synovium. The synovial reaction destroys the articular cartilage and attenuates the inflamed articular capsules and ligaments, permitting the joints to be drawn into abnormal positions by muscle imbalance. The diseased synovium surrounding the tendon invades the tendons, with subsequent gradual dissolution of the normal fibers of the tendon. There follows gradual stretching of the tendon, diminution in tendon strength, and ultimately tendon rupture.

Volar subluxation of the metacarpal phalangeal joints with associated ulnar deviation of the finger is a constant finding in advanced rheumatoid disease. The ulnar deviation of the fingers is the end result of several factors. The relatively greater ulnar mobility of the metacarpal phalangeal joint, the ulnarward pull of the long flexor tendons, the pull of the lumbrical muscles, obliquity in an ulnar direction of metacarpal heads, and positional factors all contribute to producing this characteristic deformity.

Synovectomy. The use of synovectomy to remove the diseased synovium from distended joints and from around the flexor and extensor tendons is now a well established surgical procedure. The indications for synovectomy for either joints or tendons is the presence of proliferative synovium when it has not responded to aggressive medical management within three to six months from the onset of therapy. The aim of this surgical procedure is to prevent tendon rupture, destruction of the articular cartilage, and attenuation of the ligaments of the joints. In order to be effective, an effort is made to remove all of the synovium around the tendons, including intra-tendinous nodules.

Similarly, within the joints, all synovium should be removed and the tendons repositioned, but care is taken not to weaken the already distended joint ligaments. In the patient whose disease is controlled with medication, the synovectomy may result in prolonged remission

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in the operated area; whereas, in those cases where the disease is progressive, one is likely to see a reappearance of synovitis in the operated joint in 12 to 18 months. Even in these instances, one has extended the functional life of the involved structure.

Silastic joint replacement. It is in the correction of ulnar draft and volar subluxation of the metacarpal phalangeal joints that silastic joint replacement has been most useful. In the early course of the disease, synovectomy of these joints may prevent this deformity. Tendon repositioning is also useful in the patient under good medical control and without articular damage. In the advanced deformity with articular damage, the use of silastic joint replacement has given excellent results.

The operative procedure is performed using general or regional nerve block anesthesia. The metacarpal head is excised and a complete synovectomy of the joint performed. A channel is then made in the metacarpal and proximal phalanx to accept the prosthesis. The extensor tendon is then reconstructed to exert a more radial pull and a tenotomy of the ulnar intrinsic muscles is performed. The hand is placed in a large bulky bandage for five days after which physical therapy is started. Within three weeks following surgery, most patients will regain useful function in the newly reconstructed joints.

The long-term results following this procedure, as compared with the synovectomy, have been more gratifying. The patient is usually able to regain 60 to 75% of the normal joint motion; stability in the joint is regained, and pain in these joints is relieved.

In the proximal interphalangeal joint affected by rupture of the central slip of the extensor tendon, or the so-called boutonniere deformity, silastic joint replacement has also been undertaken when the articular cartilages have been destroyed. Through this procedure, some active extension of the joint can be gained. Similarly, in the stiff proximal interphalangeal joint resulting from intrinsic contracture, and giving a Swan-neck deformity, silastic joint replacement has a distinct advantage over fusion of this joint in that same degree of active flexion can be regained.

Summary. Great strides have been made in the surgical treatment of rheumatoid deformities of the hand, both in preventing deformity and restoring function. Hand surgery should be performed as a part of a well organized multi-disciplined treatment regimen involving a rheumatologist, physiatrist, and orthopedist with the common goal of rehabilitation of the total patient. ■

6. Intrasynovial therapy with adrenocorticosteroid esters

Daniel J McCarty, MD, Milwaukee, Wisconsin

SINCE HOLLANDER and his coworkers described the use of local injections of corticosteroids in 1951, the effectiveness of this technique has been improved greatly by the development of microcrystalline suspensions of the less soluble esters. The therapeutic goals for intrasynovial corticosteroid injection are: 1) to help correct deformities accompanying inflammation of peripheral joints or tendons; 2) to help control inflammation in one or more particularly troublesome joints; 3) to provide optimal means of controlling a monarticular or oligoarticular arthritis; 4) to provide "medical synovectomy;" and 5) to provide definitive treatment for isolated sterile inflammatory conditions such as acute, nonspecific tenosynovitis and acute and subacute bursitis.

It is important to realize that intrasynovial corticosteroid injection is considered an adjunctive form of treatment and is rarely the only means of treating a given condition. The selection of a particular product should be based on the natural history of the condition being treated, the local pathologic changes, and the therapeutic goals. Since corticosteroids are basically anti-inflammatory drugs, they should not be used to treat lesions that are not inflammatory. Like all drugs, injectable steroids constitute a two-edged sword. Their use assumes a knowledge of the relevant anatomy and a reasonable degree of skill in arthrocentesis of various joints, tendons, and bursae. Steroids not injected into a synovial space will not do the job intended by the physician (Table 1).

Correction of Deformities. The range of motion of joints affected with rheumatoid arthritis, psoriatic arthritis, and the like may be limited as the flexor muscles contract and the extensors atrophy. Such deformity may occur rapidly (a few days or weeks), most notably in knee and elbow joints. As these joints can be injected easily, local steroid therapy can be given readily. After 24 to 48 hours, as inflammation subsides, physical therapy in the form of hot or cold applications and range of motion exercises can be confidently expected to correct the deformity, with complete or nearly complete recovery of lost function. The sooner flexion deformity is treated, the better the result.

If the natural history of the disease is one of sustained inflammation with progressive deformity, as in rheumatoid arthritis, a very

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TABLE I—Therapeutic characteristics of selected corticosteroids

Generic name	Approximate duration of effect in rheumatoid arthritis	USUAL DOSE* Knee joint	Finger joint
Hydrocortisone acetate	6 days	25-50 mg	5-10 mg
Hydrocortisone tertiary butylacetate	12 days	25-50 mg	5-10 mg
Prednisolone tertiary butylacetate	14 days	20-40 mg	5 mg
Triamcinolone hexacetonide	28 days	20-40 mg	5 mg

*Other joints require intermediate doses.

long-acting corticosteroid can be chosen to achieve a "medical synovectomy." It is our practice to rest a joint for a prolonged period of time after injecting long-acting steroids. In addition to preventing additional inflammation, this practice spares the cartilage from possible harmful effects of the drug. It is important to take a splinted joint out of its splint and put it through a full range of motion daily.

We typically protect a knee or other weight-bearing joint for six to eight weeks after the injection of triamcinolone hexacetonide, using bed rest or crutch walking or both. We use slings for shoulders or elbow joints and splints for wrists, carpal, and small hand joints for at least three weeks after injection. As with surgical synovectomy, late recurrences are common. The ability of this compound to produce tissue atrophy is great. For this reason, it should not be injected other than intra-articularly. Even the drug leaking out of the joint along the needle track has produced cosmetically undesirable effects in the skin and subcutaneous tissue. Because of these complications, a decision to use either medical or surgical therapy to control inflammation is best made in consultation with a qualified rheumatologist. ■

ABSTRACT WISCONSIN AUTHORS

Effect of aorto-coronary by-pass operation on factors precipitating angina

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The relief of angina pectoris afforded by the aortocoronary bypass operation, as reflected in absence of symptoms, and its possible modification by the factors triggering the angina was studied in 271 male and 44 female patients. One year after the operation no angina was experienced by 85% of the male patients who previously had symptoms on walking or following a meal. Angina triggered by emotional stress or exposure to cold was relieved in 68 and 73% of the patients, respectively. A similar substantial relief of angina was observed in the female patients. In contrast, the patients with angina pectoris who did not have the bypass operation because of a less severe coronary artery occlusion experienced less extensive relief of angina one year after arteriography. These results indicate that the aortocoronary bypass operation can afford a relief of all symptoms of angina pectoris in a considerable proportion of the patients regardless of the factors triggering the symptoms. ■

ABSTRACT WISCONSIN AUTHORS

Breast carcinoma in a young man

Ali Motamen Tavaf, MD, of the Department of Surgery and Rocco Latorraca, MD, from the Department of Pathology at Trinity Memorial Hospital in Milwaukee were co-authors of a paper entitled "Breast Carcinoma in a Young Man." This was published in the July 1978 issue of the *Archives of Surgery*.

They reported a case of breast carcinoma in a 25-year-old man. The patient had sustained a blow to his nipple 18 months before and a lump appeared one week after the injury. The breast tumor was fixed to the skin of the areola and to the underlying fascia. Two large nodes were palpable in the axilla. Biopsy revealed infiltrating duct carcinoma with scirrhous response. Subsequently he had a modified radical mastectomy and was found to have metastasis to the axillary lymph nodes.

The authors stated that this is only the seventh well-documented instance of carcinoma of the breast occurring in a 25-year-old or younger man to be reported. They found in the literature that breast carcinoma had been reported in a boy of 5 and another in a boy 6 years of age. A familial incidence of breast cancer in men has been reported and in this patient there was the prevalence of cancer in his paternal grandparents and great-grandparents.

Although it is not infrequent for patients with breast carcinoma to give a history of breast trauma, no definite correlation between the trauma and the carcinoma has ever been made.

Even though there was no evidence of metastasis beyond the axillary lymph nodes, adjuvant therapy was instituted.—VSF ■

The effect of the Lessard Decision on adult commitment statistics at Milwaukee County Institutions

Ashok Ramprakash Bedi, MD, Milwaukee, Wisconsin

• A study of the impact of legal manipulation on adult psychiatric commitments is reported. It examines the impact of applying a stringent legal framework to the commitment process. The author focused on examining its impact on various levels of the commitment process. While this made a statistically significant impact on adult involuntary admission to a psychiatric unit in the first instance and on the 48 hours later probable-cause hearings, it made an insignificant impact on the number of probable-cause positives who were finally committed. Further implications of these findings are presented.

WISCONSIN STATUTES

Step 1. An adult alleged to be mentally ill can be committed to a psychiatric unit for 48 hours observation in the first instance after observing the proper procedural protocol by: (a) police; (b) three relatives, or friends who know the patient; (c) admitting doctor at psychiatric facility; and (d) physician in the community who knows the patient.

Since the revision of the Wisconsin Mental Health Statutes following implementation of the Lessard Decision, the criteria defining the committable mental illness were refined and the provisions for c and d above were eliminated.

Step 2. Within 48 hours of being involuntarily committed to a psychiatric facility, there is a probable-cause hearing, where the judge decides whether there are legitimate and adequate grounds for the patient to be committed for a further 14 days of observation.

Step 3. After 14 days of observation and evaluation by two court appointed psychiatrists, there is a final disposition court hearing, where the final decision is made whether there are adequate grounds for further commitment of the patient to extended psychiatric care.

LESSARD DECISION

The case of Alberta Lessard *vs* Wisconsin Department of Health and Social Services[1] stands as an important landmark in Wisconsin statutes for commitment of psychiatric patients. It laid down precise criteria for commitment of patients. It also defined the procedural guidelines for the commitment process. It made mandatory the requirement of written and oral Notice of Rights, the format for the probable-cause hearing, the final hearing, among others.

DESIGN OF THE STUDY

The study compares all adult admissions at Milwaukee County psychiatric units for a four-month period.

Period A. Nov 1, 1975 - Feb 28, 1976, before implementation of the Lessard Decision with a similar four-month period.

Period B. Nov 8, 1976 - Mar 8, 1977, after implementation of the Lessard Decision.

We have examined what proportion of total examinations were involuntary admissions in both periods. Comparisons have been made of what happened at various levels of the commitment process in both periods. Tables 1 to 5 are self-explanatory and implications of each comparison are presented.

Table 1. There is a significant reduction in the number of patients being committed since implementation of the Lessard Decision. This

Key for tables: Period A = Nov 1, 1975 to Feb 28, 1976. Period B = Nov 7, 1976 to Mar 8, 1977. MCI = Milwaukee County Institutions. L. of Sig. = Level of significance.

Table 1—Involuntary commitment statistics for adult psychiatric population at Milwaukee County Institutions for four-month period

	Period A	*Period B*
Total adult admissions at MCI	1010	830
Total adult involuntary admissions at MCI	336	156
Total police detentions	198	95
Invalid police detentions	nil	67
Total applications for temporary custody	21	Not applicable
Total doctor's detention	24	Not applicable
Patients found to have a probable cause after 48 hours	131	49
Patients found to have no probable cause, yet opted for voluntary inpatient treatment after 48 hours	85	nil
Patients finally committed to extended psychiatric treatment at final hearing	102	40
Patients not committed at final hearing, yet opted for voluntary treatment	2	2

Presented at the Annual Conference of the Wisconsin Psychiatric Association, June 3, 1977, in Fond du Lac.

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reduction has come about by reducing the number of patients who are provisionally committed for 48 hours in the first place. But, on closer study, the proportion of valid initial commitments, who are found to have a probable cause, has actually increased. However, the proportion of probable-cause positives, who are finally committed at a final hearing 14 days later, has remained virtually the same.

Another interesting observation from Table 1 is that a significant proportion (87/336=25.89%) of the patients, who were initially committed for 48 hours under the older act, signed in for voluntary treatment, even though they were found to have no probable cause at a probable-cause hearing or were not finally committed at a final hearing.

In Period B only 2 out of 156, or less than 1%, signed for voluntary treatment. These patients (154) now have their entry permit blocked for psychiatric treatment. The fate of these patients remains to be seen.

Table 2. From Table 2 it is clear that there is a statistically significant decrease (up to 14.4%) in the number of adult psychiatric inpatients at Milwaukee County Institutions who come in under some form of commitment. At any time the possibility exists that up to *18.8%* of inpatient population is likely to be involuntarily detained, compared with 33.27% in Period A. However, there is no room for complacency, since in the United Kingdom only *4.2%* of total adult psychiatric patients come in under some form of civil commitment, compared with our current rate of 18.8%.[2] From Table 2 it is evident that implementation of the Lessard Decision has made a statistically significant impact on the proportion of adult psychiatric inpatients at Milwaukee County Institutions that is now constituted by finally committed patients. What impact the invalid Police Detentions would have on this apparent reduction in finally committed patients is difficult to postulate.

Table 3. This table points out that with the implementation of the Lessard Decision we have more stringent guidelines for initial commitment. Hence, fewer patients are initially committed for 48 hours, in the first instance. But, once in, there is a 14.5% increased likelihood of being finally committed.

In other words last year, under the old statutes, when the courts were presented with a larger bulk of involuntary admissions, based on less stringent criteria, the courts

Table 2—Proportion of total adult admissions at Milwaukee County Institutions that were involuntary and of those that finally were committed for Period A, compared with Period B

	Period A	*Period B*	*Difference*
Total adult admissions at MCI	1010	830	
Total adult involuntary admissions at MCI	336	156	
Percentage of total admissions that were involuntary	33.27%	18.8%	14.47% (Chi^2=48.71 D.f.=1 L. of Sig.= 0.001)
Patients finally committed at final disposition hearing	102	40	
Percentage of total admissions that were finally committed	10.10%	4.82%	5.28% (Chi^2=2.6349 D.f.=1 L. of Sig.= 0.001)

Table 3—Proportion of total adult involuntary admissions at Milwaukee County Institutions that were found to have a probable cause and of those that were finally committed

	Period A	*Period B*	*Difference*
Total adult involuntary admissions at MCI	336	156 (including invalid police detentions)	
Patients found to have a probable cause at probable-cause hearing ..	131	49	
Percentage of valid involuntary admissions that were found to have a probable cause	33.99%	55.0%	16.06% (Chi^2=44.71 D.f.=1 L. of Sig.= 0.001)
Patients finally committed	102	40	
Percentage of involuntary admissions finally committed (including invalid police detentions)	30.36%	25.64%	4.72% (Chi^2=17.826 D.f.=1 L. of Sig.=0.2) (Non Sig.)
Percentage of involuntary admissions finally committed (excluding invalid police detentions)	30.36%	44.9%	14.54% (Chi^2=6.724 D.f.=1 L. of Sig= 0.01)

Table 4—Proportion of adult involuntary admissions at Milwaukee County Institutions who were found to have a probable cause that were finally committed

Total adult involuntary admissions at MCI found to have a probable cause		Total adult involuntary admissions at MCI finally committed	Percentage of probable-cause positives finally committed
Period A:	131	102	77.86%
Period B:	49	40	81.63%
Difference:			3.77%

$Chi^2 = 0.3022$ D.f. = 1 Level of significance (Non-significant)

Table 5—Admission statistics pertaining to the doctor's detention

Total adult admissions at MCI for Period A	1010
Total adult involuntary-admissions at MCI for Period A	336
Doctors' detentions for Period A	24
Percentage of total adult admissions that are doctors' detentions	2.38%
Percentage of involuntary admissions that are doctors' detentions	7.14%

exercised their own discriminatory judgment to filter out unnecessary admissions. Under the new statutes 16.06% more involuntary admissions (valid) are found to have a probable cause at a probable-cause hearing.

Superficially this might sound paradoxical, that even with more stringent criteria, a significantly higher proportion of initial valid admissions are found to have a probable cause. On closer analysis it is evident that under the old statutes, when the guidelines for commitment were less specific, the courts exercised an appropriate degree of discriminatory judgment, and a fewer proportion of the larger mass of initial commitments were further committed for 14 days.

Another interesting observation is that under the revised statutes, once in for 48 hours there is a 55% chance of being further detained for 14 days, compared with only 39% under the older act.

Table 4. These data are statistically insignificant. In other words the new law has made no impact at this stratum of commitment process at final disposition hearing. One of the criticisms of the old statutes was that the legal procedural guidelines were not strictly adhered to, perhaps implying that the probable-cause hearing and the final hearing were somewhat of a mock court. This criticism does not bear out under objective analysis.

A higher proportion of the large bulk of initial admissions, up to 61%, were filtered out at probable-cause hearings under the older, less stringent statutes. While the more stringent reduced the mass of initial admissions, the courts have to filter out only 45% of these initial admissions.

Once having been processed at a probable-cause hearing, there is no difference of any significance in the percentage of those patients who are committed at a final hearing (average 80%).

Table 5. Another relevant observation is about the doctor's detention. Somehow there was a myth that this was abused. The data show only 41 out of 336 (12.2%) of initial commitments to be doctors' detentions. The actual doctors' detentions (excluding Application for Temporary Custody) constitute only 2.38% of total adult admissions and 7.14% of total involuntary admissions—not a very significant amount.

This provision has now been eliminated under the new statutes; and although I am not recommending its reinstatement per se, the admissions were not to the extent that it would have been significantly abused in the past.

DISCUSSION

In perspection I would agree that the revised statutes are certainly enlightened pertaining to:

1) The constitutional safeguards for the rights of our psychiatric patients,

2) perhaps in eliminating a proportion of involuntary admissions that were unjustified, thus protecting these patients from the stigma of psychiatric hospitalization,

3) laying down procedural guidelines for the commitment process, and

4) defining the precise criteria for commitment.

On the other hand the new statutes could be made more viable by catering to the following pitfalls:

A. It is evident that the police, who are now the key implementers of the new statutes, are reluctant and perhaps ill-prepared to implement them, as evidenced by the fact that 67 out of 95 applications for commitment made by them were technically invalid.

From my previous experience, especially with the British Mental Health Act,[3] I can make two specific suggestions:

1) Every person, who is held by the police for possible commitment, must be held in custody to be evaluated by a psychiatrist before the course of action is decided by the police. This is facilitated in Britain because the police can rely on the resources of nationalized medicine. Perhaps for these evaluations, different arrangements might have to be made in Wisconsin. The County might provide the police a full-time or a part-time psychiatrist for these evaluations.

2) The Police Academy must have in its curriculum an enhanced emphasis on mental health education on a regular and ongoing basis, in liaison with the psychiatric community.

B. Often prolonged hospitalization and commitment are not war-

ranted. Instead, a temporary commitment towards brief hospitalization (four to six weeks) might defuse many a psychosis and, incidentally, is the most common form of commitment in the United Kingdom.[4] It is based upon the petition of next of kin or, in its absence, the Protective Services, upon recommendation of two independent physicians, one of whom must be a certified psychiatrist. It would be very suitable and meet the need of the day if some similar form of short-term psychiatric commitment could be improvised within the parameters of current Wisconsin statutes.

C. Finally, the underlying theme of the Lessard Decision and the revision of Wisconsin statutes seems to be based on the presumption that psychiatric hospitalization, especially against the patient's will, is an extremely hazardous intervention which not only cuts across one's civil rights but also leaves a lifelong stigma of being branded with a mental hospitalization.[5]

On reviewing the commitment statistics at Milwaukee County Institutions, I was intrigued by the fact that neither before the Lessard Decision nor after was there a provision for committing patients to outpatient care. As a matter of fact, one of the criteria for commitment is exhaustion of all outpatient resources. In the United Kingdom it is a common practice to place suitable patients under compulsory outpatient treatment, and only if the patient violates the agreement is the patient reviewed for commitment to alternative modes of treatment.[6]

I feel similar provisions for commitment towards outpatient psychiatric treatment ought to be made in the Wisconsin Statutes; and our judges ought to interpret Sec. 51.42 final disposition not only to mean commitment to inpatient care but also commitment to outpatient community psychiatric treatment in suitable cases.

ACKNOWLEDGMENT: This study was made possible through the cooperation of the Medical College of Wisconsin, Department of Psychiatry and Mental Health Sciences, and the Milwaukee County Mental Health Center. William J Crowley, MD, Clinical Director, was very helpful in providing ongoing consultation for various facets of Wisconsin law. Mr Pat Sloane, Court Liaison, and Ms Mary Jane Stanke, Medical Records Technician, were most helpful in compiling the statistical data.

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ABSTRACT/WISCONSIN AUTHORS

Vitamin B_6 deficiency in cancer patients

CAROL POTERA, MS; D P ROSE, PhD; and R R BROWN, PhD; University of Wisconsin Medical School, Madison, Wis: *Am J Clin Nutrit* 30:1677-1679 (Oct) 1977

Cancer patients, especially those with advanced disease, frequently exhibit a loss of cell-mediated immune response that may contribute to systemic spread of the tumor. A deficiency of vitamin B_6 can also produce an impaired immune response. Pyridoxal phosphate is an essential coenzyme for several biosynthetic reactions concerned with antibody production and cell-mediated immunity.

The plasma pyridoxal phosphate concentration was significantly lower in patients with advanced breast cancer than in healthy controls, but the urinary 4-pyridoxic acid excretion was normal. Plasma pyridoxal phosphate levels were also low in women with widespread cancer in other primary sites (colon and reproductive organs), but were normal in early disease.

The low plasma pyridoxal phosphate levels in cancer patients with advanced disease could arise from a low dietary intake of vitamin B_6; however, the urinary 4-pyridoxic acid excretion was normal although it decreases in experimental dietary vitamin B_6 deficiency. Preliminary studies show that the activity of an erythrocyte membrane-bound phosphatase which is present in both cancer patients and controls is inversely related to the concentration of plasma pyridoxal phosphate.—DOROTHY J BUCHANAN-DAVIDSON, PhD ■

Therapeutic options in Meniere's disease

I KAUFMAN ARENBERG, MD, University of Wisconsin Center for Health Sciences, Madison, Wis; and R F Bayer, MD: *Arch Otolaryngol* 103:589-593 (Oct) 1977

Emphasis on the treatment of Meniere's disease has recently shifted from concentration of the vertiginous component alone, to include conservation or improvement of hearing as well. This presentation tabulates the current otologic literature's report on both the medical and surgical options available for the treatment of Meniere's disease.

The authors conclude that more recent reports de-emphasize the vertiginous component while emphasizing the importance of the hearing component in the evaluation of the efficacy of any therapeutic modality.

It is widely accepted now that no medical treatment is available for Meniere's disease, which will alter the long-term natural course of the Meniere's disease with particular regard to the hearing component. Medical treatment is only of value in and during the acute exacerbations, and in the very earliest stages of Meniere's disease. Furthermore, these reports indicate that endolymphatic sac decompression and drainage surgery alone offers a considerable chance for conservation or improvement in hearing, as well as relief of vertigo in early cases of reversible fluctuant hearing losses. The audiometric glycerol test is very helpful in distinguishing which patients will benefit from the sac surgery. Both in terms of the vertigo and hearing components for non-reversible or non-fluctuating hearing losses with hearing worth conserving, vestibular neurectomy yields the best results. ■

Automated laboratory screening

An analysis of value in a nursing home population

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• The use of automated laboratory screening tests remains controversial. In this study 158 nursing home patients over the age of 65 were screened with a blood profile as part of their data base. The abnormal values were analyzed in terms of their clinical benefit to the patient. New diagnoses were made in 13 percent of these patients; 6 percent were felt to benefit directly from the screening. Five percent of the patients were found to be hypothyroid. With the inherent difficulties in making a clinical diagnosis of hypothyroidism in the elderly patient, it would seem advisable to screen elderly patients at regular intervals. With the exception of thyroid function tests, automated screening blood profiles in elderly patients are of limited value.

AUTOMATED LABORATORY screening has been an accepted part of medical practice for many years. However, the value of these tests in asymptomatic individuals, as well as the routine yearly physical, has been recently questioned by numerous authorities.

Kovin, Pearce, and Stanley[1] reviewed 1,000 patients admitted to a general hospital who had admission blood screening tests. Two thousand, two hundred and twenty-three abnormal results were found; 675 were predicted on clinical assessment; 1,325 did not yield new diagnoses. The remaining 223 abnormal tests lead to 83 new diagnoses in 77 patients. On evaluation of the new diagnoses, none was unequivocally beneficial to the patient. Their conclusion was that although screening might reveal many abnormal test results, clinical benefits were not impressive.

Frame and Carlson[2] reviewed periodic health screening using specific criteria. In determining whether a disease should be screened for in the asymptomatic population, they developed the following six criteria:

1. The disease must have a significant effect on quality and quantity of life.
2. Acceptable methods of treatment must be available.
3. The disease must have an asymptomatic period during which detection and treatment significantly reduce morbidity and/or mortality.
4. Treatment in the asymptomatic phase must yield a therapeutic result superior to that obtained by delaying treatment until symptoms appear.
5. Tests must be available at reasonable cost to detect the condition in the asymptomatic period.
6. The incidence of the condition must be sufficient to justify the cost of screening.

They found in evaluating a long list of common diseases that routine screening was seldom justified in the asymptomatic population. There were notable exceptions, however, such as the Pap smear.

The present study was designed to determine the value of automated laboratory blood screening tests in an elderly nursing home population.

METHODS

Selections of subjects

Patient care responsibilities at Rolling Hills Nursing Home, Sparta, Wisconsin were assumed by two family physicians from the Krohn Clinic in Black River Falls, Wisconsin in April 1976. Medical records were converted to the problem-oriented format. All patients underwent a complete physical examination; pertinent medical history was obtained from the patient and from previous medical records by the nursing home personnel. Multiphasic screening tests included an electrocardiogram, urinalysis, and a blood profile. With this data base, problem lists were generated for each patient.

One hundred and fifty-eight patients over the age of 65, who had not had blood profiles drawn in the previous two years, were included in this study.

Laboratory screening

The blood profile included serum triglycerides, cholesterol, bilirubin, albumin, globulin, lactic dehydrogenase, alkaline phosphatase, SGOT, creatinine, glucose, blood urea nitrogen, uric acid, phosphorous, chloride, sodium, potassium, calcium, white blood cell count, hemoglobin, C-reactive protein, T_4, rheumatoid factor, and VDRL. This test was drawn in the postprandial state, approximately two hours after breakfast.

Abnormal values were defined as those equal to or greater than two standard deviations above, or in some instances below, the accepted normal range. Exceptions to this definition were the T_4 with any value below the normal range considered abnormal, and the postprandial blood sugar, with abnormality determined by an age-adjustment nomogram.[3]

Analysis of abnormal values

Abnormal values were evaluated in the following way:

1. Were further laboratory tests performed to verify and/or clarify the abnormality?
2. Was a new diagnosis made?

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3. If a new diagnosis was made, did the treatment plan change?
4. If a new diagnosis was made, could it have been made as easily on physical examination?
5. Was the quality of life improved or the life span lengthened because of this finding?

(These conditions have been listed for each patient in table form which is available from the authors.)

RESULTS

Thirty-seven percent of the patients had abnormal results as defined above. Forty-three percent of the patients with abnormal results (25 patients) had further laboratory tests performed to verify and/or clarify the original abnormality. In this group of patients, 80 percent had new diagnoses established (including two new diagnoses in two patients). These 20 patients represented 13 percent of the total study population.

Changes in treatment plan were made in 18 of the 20 patients with new diagnoses. Although difficult to verify, 10 patients (6 percent of the study population) were felt to benefit from the screening procedure in regards to improvement in quality of life or lengthening of life span.

Problems arose in the area of defining diabetes mellitus in the elderly patient, with the relative glucose intolerance related to the aging process. And, of course, the benefits derived from lowering the blood sugar with appropriate treatment remain controversial, especially the effect on vascular complications. It was felt that with the present evidence, no significant improvement in quality of life or lengthening of life span could be attributed to treatment of these metabolic abnormalities.

A similar problem arose in analyzing elevations of triglycerides and cholesterol. Benefits from treatment have not been clearly demonstrated in the elderly patient.

The finding of positive rheumatoid factor in patients without clinical evidence or history of arthritic symptoms was interesting. Inclusion of this in the screening profile seems of little value. Inclusion of the C-reactive protein also seems of little screening value (the tendency to add more and more tests to the screening profile goes on unchecked in spite of very little specificity or usefulness of many of the tests!).

Many of the abnormalities not pursued related to renal function, and probably represented mild renal insufficiency. Two octogenarians with multiple medical problems showed homogenous gamma globulin elevations; the patients' ages and significant other problems were considered contraindications to bone marrow examinations and other invasive procedures.

DISCUSSION

The overall benefits of automated screening to this group of elderly patients were not impressive. However, certain findings in the study were remarkable. The finding of eight patients (5 percent) with primary hypothyroidism was striking. It might be argued that several of these patients could have been diagnosed with careful history taking and clinical examination. This may have been true in one or two of these patients. However, the "typical" signs and symptoms of hypothyroidism are less common in the elderly hypothyroid patient. Bahemuka and Hodkinson[4] found only 28 percent of their series of laboratory diagnosed elderly hypothyroid inpatients to display the "classical" signs and symptoms of hypothyroidism; more than half of the patients displayed a "nonspecific picture," and several patients presented with predominately psychotic symptoms other than dementia.

All the hypothyroid patients were included in that category felt to benefit from a treatment change, although this, in some instances, was difficult to document.

CONCLUSIONS

New diagnoses were made in 13 percent of an elderly nursing home population through the use of automated laboratory screening tests. Six percent of the study population were felt to benefit directly from the screening.

The incidence of primary hypothyroidism (5 percent) discovered through the screening was remarkable. Estimates of the incidence in the elderly population varies from 2 to 4 percent in the recent literature.[4,5]

With the inherent difficulties in making the clinical diagnosis of hypothyroidism in the elderly patient, it would seem advisable to screen these patients at regular intervals, perhaps those with a relatively low-normal T_4 on a yearly basis, and others every two to four years. Borderline-low T_4 abnormalities also could be pursued with TSH determinations to determine the adequacy of the gland's output. Of course, clinical observations would be important in determining the frequency in each individual.

With the exception of thyroid tests, automated screening profiles in elderly patients are of limited value.

ACKNOWLEDGMENT: We are indebted to Carolyn Burge, Freda Bue, and Maxine Bober, RN for their technical assistance.

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Squamous cell carcinoma of the nasal cavity

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MALIGNANT TUMORS of the nasal cavity are rare and hence are usually grouped together with tumors of the paranasal sinuses. Since their behavior, treatment, and prognosis differ from tumors of the paranasal sinuses, they merit separate consideration. Their frequency is second only to that of the maxillary antrum.

Material

Eighteen cases of malignancy of the nasal cavity were seen at the University of Wisconsin-Madison Department of Radiotherapy between 1958 and 1975. Four patients who had histology other than squamous cell carcinoma (two malignant melanoma, one angiofibrosarcoma, one extramedullary plasmacytoma), three patients who had treatment only to metastatic nodes, and one patient who had treatment of the recurrent primary irradiated seven years prior, were excluded.

Our analysis is limited to the 10 patients with epidermoid carcinoma who had treatment of the primary tumor at our institution. All of the patients had histological confirmation of the diagnosis. Equal numbers of males and females were seen. The most frequent symptom was nasal obstruction, followed by epistaxis and ulceration in the nose. The tumors were staged according to the TNM system proposed by Lederman[1] as shown in Table 1.

History of exposure to fumes or smoking was not documented in all the patients. Of six definite histories, four were smokers and two were nonsmokers. Three patients gave histories of exposure to fumes and dust such as that from furniture manufacturing, paper mills, and factories.

Treatment

Seven of the 10 patients had biopsy as the only procedure prior to radiotherapy. Two other patients had resection of the septum before irradiation, and one patient was irradiated for recurrence after two definitive surgical attempts within three months. In eight patients only the primary lesion was treated. One patient who had neck nodes initially, received treatment to the neck as well. Also, one patient was treated electively to the neck. All of the patients received treatments with megavoltage (Co^{60}, 1 MeV, 4 MeV) units. The nasal cavity was treated with a single anterior field, wedged oblique fields, or a combination of the two. Tumor doses ranging from 5000 to 7000 rad in five to eight weeks were used, the most frequent being 6000 rad in five weeks. Two patients were treated additionally, with intracavitary radium.

Results

Radiotherapy effectively controlled the primary tumor in eight patients, but failed locally in two patients. One recurred about five years after radiotherapy and later developed metastases to the T_7 vertebra. It is a moot point whether it was a recurrence or a new primary tumor. The other patient had

Table 1—TNM classification (Lederman[1])

PRIMARY TUMOR (T)
- T_1 : limited to region of origin
- T_2 : spread limited horizontally to the same region or two adjacent but vertically related regions
- T_3 (a) : involving three regions with or without involvement of orbit
- (b) : extending beyond upper jaw

REGIONAL LYMPH NODES (N)
- N_0 : no palpable lymph nodes
- N_1 : mobile homolateral lymph nodes
- N_2 : mobile contralateral or bilateral lymph nodes
- N_3 : fixed homolateral or bilateral lymph nodes

DISTANT METASTASES (M)
- M_0 : no evidence of distant metastases
- M_1 : distant metastases

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This work was supported in part by NCI supported Multidisciplinary Program in Radiation Oncology, No. 5 PO1 CA19278.
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Table 2—Summary of cases of carcinoma of the nasal cavity

Case and year	*Age and sex*	*Location of lesion*	*Stage*	*Histology*	*Procedures preceding radiation*	*Radiation source*	*Radiation dose/days/fractions*	*Recurrence and metastases*	*Subsequent treatment*	*Survival and status (yrs : mos)*
1/1958	72 F	Turbinates	$T_2N_0M_0$	Squamous	Biopsy	1 MeV	5800/35/28 5000/30/24 neck	No	—	15:0 NED
2/1961	61 M	Septum	$T_3N_1M_0$	Squamous Grade III	Biopsy	Radium implant 1 MeV	7200r 2800/15/11 6300/51/29 neck	Yes, recurrence and neck node	Chemosurgery Radical neck dissection Plastic surgery reconstruction	2:4 D_{oc}
3/1963	45 F	Septum	$T_3N_0M_0$	Squamous Grade III	Resection and reconstruction	1 MeV Radium implant	5000/34/25 9000r	No	—	9:0 NED
4/1966	50 M	Nostril	$T_3N_0M_0$	Transitional Grade III	Biopsy	Co^{60}	6000/37/30	Yes, recurrence and distant metastasis	Radiation to T_7	6:4 DWD
5/1968	56 M	Septum	$T_3N_0M_0$	Squamous well diff.	Biopsy	Co^{60}	7000/43/30	Yes, Neck node	Surgery and Radiation	7:3 DWD
6/1970	73 F	Septum	$T_1N_0M_0$	Anaplastic	Resection	Co^{60}	6000/35/25	No	—	4:7 D_{oc} *(1)
7/1971	44 M	Septum	$T_1N_0M_0$	Squamous Grade III	Polypectomy	4 MeV	6600/44/33	No	—	6:4 NED
8/1972	85 F	Middle Turbinate	$T_2N_0M_0$	Undifferentiated	Biopsy	4 MeV	6600/48/32	No	—	2:7 D_{oc} *(2)
9/1974	57 M	Septum	$T_2N_0M_0$	Squamous well diff.	Resection (twice)	4 MeV	5700/51/27	No	—	2:5 NED
10/1975	82 F	Middle Turbinate	$T_1N_0M_0$	Anaplastic	Biopsy	4 MeV	6000/33/24	No	—	2:2 NED *(3)

NED = No Evidence of Disease. D_{oc} = Died of Other Causes. DWD = Died With Disease.

*Second primary : (1) Multiple Myeloma (2) Histiocytic Lymphoma (3) Breast carcinoma.

a massive T_3 lesion involving the columella, septum, floor of the nasal cavity, and margins of the upper lip with metastatic neck nodes. Regrowth of disease was noted within six months after 7000 rad intracavitary radium and 2775 rad external radiation with 1 MeV in 15 days. The recurrent lesion was removed by chemosurgery. Later he underwent radical neck dissection for metastatic nodes. One year later he died after a reconstructive procedure, without evidence of disease.

One of the eight patients with the primary tumor controlled developed neck node metastases four years after irradiation to the primary site. Since the nodes were adherent to the mandible, hemimandibulectomy and radical neck dissection were done. The neck was irradiated for recurrent metastatic nodes. He later developed lung metastases and died seven years after treatment to the primary site, which showed no evidence of recurrence.

Three patients had second primary tumors. One patient had carcinoma of the breast six months prior to the diagnosis of carcinoma of the nasal cavity. Another patient died with multiple myeloma, chronic granulocytic leukemia, and a kidney mass. The third patient died of histiocytic lymphoma, Stage IV-B. All three patients had no evidence of carcinoma of the nasal cavity at the time of death. All of the 10 patients have been followed at least two years; seven had no evidence of disease at the time of death, or at the last followup. Details are shown in Table 2.

Discussion

In the literature tumors of the nasal cavity are considered together with tumors of the paranasal sinus. A few papers[2,3] discuss evaluation and treatment of the nasal vestibule, which is a part of the nasal fossa. Tumors of the nasal cavity tend to be exophytic and bulky and occupy the nasal cavity before they involve the sinuses and bones. The tumors of the paranasal sinuses, on the other hand, destroy the walls of the sinuses from which they arise, while growing, and protrude into the nasal cavity at a later stage. Therefore, we excluded the lesions which involved the paranasal sinuses from this series. Badib et al[4] included many cases as nasal cavity primaries, even though they primarily had involvement of the paranasal sinuses.

Many factors are considered in the literature as predisposing factors in the development of carcinoma of the nasal cavity. Atrophic rhinitis, nasal polyps,[4,5] exposure to dust and fumes in industries such as woodworking, boot- and shoemaking,[6,7] tobacco snuffing,[7] and smoking[8] are some of the listed causative factors. Because of inadequate documentation, no opinions can be offered from this series. Nevertheless, as described earlier, many gave histories of smoking and exposure to fumes and dust.

Many histologic types of tumors are noted to arise in the nasal cavity. Malignant melanoma, adenocarcinoma, reticulum-cell sarcoma, angiofibrosarcoma, extramedullary plasmacytoma, and chondrosarcoma are some of the variants reported in the literature. However, most often they are squamous cell carcinomas. In our series they were usually Grade-III or anaplastic carcinomas rather than well-differentiated carcinomas. There was no apparent correlation between the grade of the tumors and the prognosis.

The majority of the published series do not specify the treatment of choice for lesions of the nasal cavity. It could be noted that the results obtained in the cancer of the nasal cavity are better than those of the maxillary sinuses from a few series which analyze the results of the tumors of the nasal cavity and paranasal sinuses separately.[8] When tumors of the nasal cavity are studied together with the lesions of the maxillary sinuses where the treatment of choice is surgery alone or in combination with irradiation, the erroneous impression is gained that surgery is also a treatment of choice for tumors of the nasal cavity.

Radiotherapy was the treatment of choice in the few reported series confined to tumors of the nasal cavity.[1,4,8,9] Modern radiotherapy achieves better cosmetic results than surgery with equal, if not better, survival. Major surgical resections may be reserved for recurrent tumors as a salvage procedure.

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Bedrest in the treatment of chronic hypertension during pregnancy

THE FOLLOWING ARTICLE summarizes the experience at the Southcentral Wisconsin Perinatal Center in the management of chronic hypertension during pregnancy with a program of bedrest. In view of the possible deleterious effects of antihypertensives on fetal development and outcome, a program which produces good results with no apparent hazard to the fetus may be most desirable.

THE APPROACH TO treatment of the chronic hypertensive during pregnancy has undergone a gradual change during the past 20 years. There has been a move from the traditional use of bedrest and sedation toward increasing use of drugs, particularly diuretics. Some authors have advocated the same drug regimen for pregnant hypertensive patients as for their nonpregnant counterparts.

In view of the significant alterations in normal cardiovascular, hemodynamic, and metabolic physiology caused by such agents, and our concern for the possible deleterious effect of such changes on fetal development and outcome, a program of bedrest with minimal use of drugs was developed at the University of Wisconsin Perinatal Center at Madison General Hospital.

Sixty-six patients cared for in the High Risk Obstetric Clinic were managed according to the new program. All patients were known hypertensives prior to the 20th week of pregnancy and were otherwise normal. Patients were seen prenatally every two weeks until the 32nd week and weekly thereafter. They were instructed on an additional four to six hours of bedrest daily in the left lateral recumbent position. If the diastolic blood pressure did not remain below 110 mm Hg in spite of bedrest at home, the patients were admitted to the hospital. If with complete bedrest in the hospital, the diastolic blood pressure remained above 110 mm Hg the patients received hydralazine orally.

Urinary estriols were done three times per week beginning at 30 to 32 weeks and weekly oxytocin challenge tests were begun at 32 to 34 weeks. Patients were allowed to deliver at term if these two parameters of placental functions remained normal.

Table 1 summarizes the pregnancy outcome of the 66 patients studied. Of the three perinatal deaths, one was a stillborn in a patient scheduled for an oxytocin challenge test. When the patient showed up for the test, no fetal heart tones were heard. The patient failed to report decreased fetal movement for several days. Postmortem examination revealed meconium peritonitis secondary to perforation of the colon. Another death occurred following an amniocentesis when fetal bradycardia developed and the patient declined a Cesarean section. Death was attributed to injury to a fetal vessel. The other death occurred in a severe hypertensive patient with superimposed preeclampsia after a positive oxytocin challenge test was obtained. A growth retarded fetus was delivered by Cesarean section. The baby died on the third day of life of cardiovascular collapse, sepsis, and coagulopathy.

The uncorrected perinatal death rate was 4.1%; however, two of the deaths were clearly unrelated to the hypertension, thus a corrected perinatal death rate of 1.4% is obtained. This mortality rate compares

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Table 1

Number of pregnancies	*Average weeks gestation at delivery*	*Average birth weight*	*Perinatal mortality*
72	37	6.3 lb	3 (4.1%)

Table 2

	Perinatal mortality
Previous pregnancies	16.8%
Current pregnancy	6.6%

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DILEMMA: Adynamic versus organic intestinal obstruction

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"OBSTRUCTION" of the intestinal tract can occur because of autonomic nervous system dysfunction or incoordination. Such cases can simulate mechanical obstruction due to an organic lesion, (*eg*, carcinoma).

It has been established that autonomic nervous system blocking agents can cause bowel "obstruction" and examples of such occurrence are recorded by Becker *et al*[1] in their report of Paralytic Ileus Simulating Acute Intestinal Obstruction Due to Ansolysen (pentolinium tartrate). Melamed and Kubian[2] reported a case of severe bowel dilatation after the use of hexamethonium bromide.

We are reporting an additional four patients with pseudo-obstruction of the colon. All four were treated with decompression by tube cecostomy. Two patients had a cecal perforation at the time of exploration. All patients recovered. In each instance barium enema failed to reveal mechanical obstruction.

Case reports

Case 1: A previously healthy 49-year-old white male underwent arthrotomy of the left knee for degenerative arthritis. He was in good health with no previous history of gastrointestinal disease or abdominal surgery. The operation was performed under spinal anesthesia and his left leg was immobilized in a plaster cast.

On the third postoperative day he complained of some abdominal distention and pain. A roentgenogram of the abdomen was interpreted as showing "ileus." A nasogastric tube was inserted and intravenous fluids were started. The following day the patient had a mild temperature elevation and slight leukocytosis. The abdomen was distended, but soft, without rigidity or guarding. Repeat roentgenogram of the abdomen disclosed a marked distention of the cecum and ascending colon. The cecum measured 15 cm in transverse diameter. A barium enema showed no obstruction in the distal colon. The patient was taken to surgery where a tube cecostomy was performed under general anesthesia. No perforation or area of vascular compromise was noted.

His postoperative course was long, but progressed to ultimate recovery.

Case 2: A 46-year-old white female complained of abdominal pain and distention during convalescence from an abdominal hysterectomy. She was treated with suppositories and enemas, but the distention and pain persisted. On the sixth postoperative day she vomited once and her temperature rose to 103 F. Roentgenograms of the abdomen revealed distention of both the small and large intestine. The cecum measured 12 cm in transverse diameter (Fig 1). A subsequent barium enema revealed no distal obstruction.

A nasogastric tube was inserted and intravenous fluids were started. Blood cultures were obtained and sodium cephalothin was given intravenously. On the evening of the sixth postoperative day, she went into shock and appropriate measures for septic shock were instituted. A repeat roentgenogram showed no decrease in cecal size. At the time of exploration under general anesthesia no perforation or necrosis of the cecum was seen, and no mechanical obstruction nor intraperitoneal sepsis was noted. A tube cecostomy was performed. The patient had a progressive recovery, and she was discharged on the twentieth postoperative day.

Case 3: A 59-year-old white male was hospitalized with abdominal pain of five days duration. On admission he complained of pain in his back and both legs. His past history revealed two laminectomies for herniated lumbar discs. Otherwise he had been well previously.

Admission evaluation revealed a temperature of 101.6 F and leukocyte count of 21,000 per cu mm. The abdomen was distended, with tenderness and guarding in the right lower quadrant. The bowel sounds were hypoactive. A roentgenogram of the abdomen showed marked dilatation of the proximal two-thirds of the colon. A diagnosis of ruptured appendix was made. At operation a perforation of the cecum was found which had been sealed by the omentum. The appendix showed changes consistent with periappendicitis. A tube cecostomy through the site of the cecal perforation was performed. The patient had an uneventful recovery. Barium enema and proctoscopic examination done after surgery showed no distal obstructing lesion.

Case 4: A 72-year-old male had bilateral inguinal herniorrhaphies performed under general anesthesia. The anesthetic agents employed were 2% pentothal induction, halothane-nitrous oxide with anectine drip. On the fifth postoperative day the patient showed some mild abdominal distention without any signs of peritoneal irritation. X-ray films of the abdomen

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Publication support provided.

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Figure 1—Kidneys-ureters-bladder film reveals marked distention of the large and small bowel. The distention is particularly evident in the cecum where it measured 12 cm in diameter.

Figure 2—Three view abdomen: Kidneys-ureters-bladder, noted in the figure left lateral decubitus and a lateral view of the abdomen revealed marked distention of the large and small bowel. The distention is particularly evident in the cecum where it measured 13.5 cm in diameter.

showed an "adynamic ileus pattern" (Fig 2). The patient was treated supportively with intravenous fluids and a nasogastric tube was placed. The patient showed no improvement in 24 hours and a barium study was done (Fig 3). It was reported as postoperative non-obstructive ileus, diverticulosis in sigmoid and descending colon. The patient's condition did not improve, and in 36 hours his distention became more severe and he manifested, for the first time, peritoneal irritation in the right lower quadrant with rebound tenderness.

Re-x-ray films of the abdomen showed (Fig 4) marked gaseous distention of the small bowel and proximal colon, particularly the cecum. The differential diagnosis included an obstructing lesion of the transverse colon and a pseudo-obstruction of the intestine (Ogilvie's syndrome). Celiotomy revealed a perforation of the cecum. A tube cecostomy was performed through the site of the perforation. The patient made an uneventful recovery and six months later a barium study of his gastrointestinal tract showed only the diverticulosis.

Discussion

Mechanical obstruction of the gastrointestinal tract is classically described as bowel distention proximal to an area of constriction of the lumen, which beyond this point is collapsed. This is the criterion which the radiologist attempts to define in a radiologic survey of the abdomen in order to determine whether mechanical obstruction is present. However, such an approach can be misleading, and the conclusions reached may be incorrect.

We have encountered four cases of bowel dilatation simulating mechanical obstruction due to an organic lesion. Organic disease was excluded in all by surgical and radiographic studies. Distention was so marked in two instances that perforation of the cecum occurred.

It is well recognized that certain conditions such as ureteral colic, pancreatitis, and vascular occlusions of the intestinal tract can lead to "paralytic ileus" or "adynamic ileus," with localized segments of bowel distention. It is our conviction that some cases of segmental bowel distention not caused by mechanical obstruction due to an organic lesion are probably related to dysfunction of the bowel, possibly due to the imbalance of

Figure 3—Colon: Fluoroscopic and radiographic examination of the colon following barium enema, demonstrated passage of the barium from the rectum to the splenic flexure of the colon. There are numerous diverticula present in the sigmoid and descending colon, but there is no evidence of any obstructive lesion of the distal colon. Conclusion: Postoperative nonobstructive ileus, diverticulosis.

Figure 4—Marked gaseous distention of the small bowel and proximal colon particularly the cecum. The distention has increased after 36 hours. The differential diagnosis includes an obstructing lesion of the transverse colon and a pseudo-obstruction of the intestine.

the autonomic nervous system. These cases represent true obstruction of a functional variety, leading to consequences similar to those when an organic obstructing lesion exists. The appearance of plain films of the abdomen is identical with that of mechanical obstruction.

In the four cases representing isolated colon distention, "bowel dysfunction" due to imbalance of the homeostatic mechanism could be responsible for the findings described.

Gierson et al[3] recently reported three deaths due to cecal rupture caused by colonic ileus. He summarized a total of 18 cases in the literature. The disease has always occurred in association with another illness, has usually afflicted patients over the age of 55 and has only resulted when the cecum was at least 9 cm in diameter. He also reported a mortality rate of 43%, emphasizing that the prevention of cecal perforation is important.

Cecal rupture due to colonic ileus is an unusual complication of pseudo-obstruction of the colon (Ogilvie's syndrome). Low and Fairley[4] reported the first case in 1934, but they failed to recognize the syndrome, probably because ileus of the colon was unknown until Ogilvie's paper in 1948.[5]

Gierson[3] proposes the following sequence in explaining how the cecum can perforate in the absence of distal obstruction. Ogilvie in 1948, Dunlop[6] in 1949, MacFarlane and Kay[7] in 1949, and Wanebo et al,[8] 1971, demonstrated disease process not involving the bowel results in an imbalance of sympathetic and parasympathetic activity. Colonic peristalsis ceases. Wangensteen[9] showed that gas accumulates due to swallowed air, bacterial byproducts and gas from the bloodstream, entering the gut lumen by diffusion. Normally, gas is carried away by the motility of the colon and by blood stream absorption, but in an ileus distention progresses and is most severe in the cecum because of its weak wall. Increasing distention impedes blood flow resulting in necrosis of the cecal wall and perforation. Eckman[10] and Robertson[11] have shown that an incompetent ileo-cecal valve does not guarantee against cecal rupture.

The homeostatic mechanism for bowel function is served by the autonomic nervous system. Motion in the intestine is mediated by the parasympathetic (bulbosacral) system. The sympathetic (thoracolumbar) system is inhibitory, and its

action is temporary. Auerbach's and Meissner's plexuses are parasympathetic.[12]

Peristaltic waves in the bowel occur in both directions when something is in the lumen. Under ordinary circumstances the retroperistaltic waves are inhibited. Under conditions of obstruction, inhibition of retro-peristaltic waves ceases and they proceed vigorously. In the normal functioning of the colon a situation exists which its effect simulates obstruction of the lumen. From a point in the transverse colon coinciding with the border between the bulbar (vagus) and the sacral innervation, retroperistaltic waves proceed toward the cecum. Back pressure is prevented from acting on the small intestine by the ileocecal valve, thus limiting the retroperistaltic waves to the proximal colon. The valve action causes little obstruction to the entry of the material from the ileum into the colon, thus preventing the conditions of obstruction from developing at the ileocecal valve.

Mass peristaltic contractions start in the proximal colon, driving the contents into the distal colon, which takes part in the mass action, driving the feces into the sigmoid. Under proper stimulus, the sigmoid empties into the rectum, thus leading to a call to stool. Mass movements occur only a few times a day. At other times the distal colon is for all practical purposes inactive.

So-called "paralytic ileus" is due to a strong stimulus by the sympathetic nervous system. The stimulus is inhibitory and transitory and may be distributed to the entire gastrointestinal tract.

Ileus due to blocking agents, (*eg*, hexamethonium) is paralytic in type, affecting both sympathetic and parasympathetic impulses. Although the results are the same, the cause is opposite to that of the strong sympathetic impulses.

Lack of parasympathetic ganglia in the wall of the colon leads to megacolon (Hirshsprung's disease). Damage to intramural ganglia (toxins, avitaminosis) or diseased vascular supply can cause ileus or megacolon. Lesions in the medulla (possibly affecting the small intestine and proximal colon) and lesions in the sacral spinal cord or sacral nerves (affecting the distal colon) can lead to megacolon.[12]

Summary

Pseudo obstructive ileus or Ogilvie's disease is probably due to an imbalance of the homeostatic mechanism of the autonomic nervous system and can result in cecal rupture, which carries a mortality rate of 43%.[3] Four cases are presented, two of which had a perforation of the cecum. Decompression by tube cecostomy was adequate in all cases.

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ABSTRACT WISCONSIN AUTHOR

Ocular sporotrichosis mimicking mucormycosis in a diabetic

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Primary sporotrichosis of the eye is very rare; most infections are limited to the conjunctiva or adnexa. We report a case of *Sporothrix* endophthalmitis associated with necrotizing ethmoid sinusitis developing in a young diabetic man with ketoacidosis. The infection clinically resembled rhino-ophthalmic mycormycosis. Cure followed evisceration and an abbreviated course (215 mg) of amphotericin B. *Sporothrix* must now be regarded as another fungal agent capable of causing primary rhino-ophthalmic infection similar to *Mucor*. ■

PERINATOLOGY continued from page S/86

favorably with other series using antihypertensive medications.[1]

Forty-five of the patients in the study had previously delivered 101 infants. A comparison of the outcome of those pregnancies and the current pregnancy is shown in Table 2. None of the prior pregnancies included bedrest and most had included use of diuretics and/or antihypertensive medication.

Although the current series is uncontrolled, the described program of bedrest allowed for a reduction of more than 50% in perinatal mortality. Based on these results, we suggest that in pregnancy complicated by chronic hypertension, bedrest, avoidance of diuretics, and use of hydralazine only if the diastolic blood pressure remains above 110 mm Hg allows for an excellent fetal outcome.

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Hypercalcemia, metastatic calcifications and cardiac abnormalities

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• Hypercalcemia may complicate a variety of diseases. The most frequent associated disorder is malignancy, usually bronchogenic carcinoma. Myeloproliferative and lymphoproliferative diseases may occasionally be responsible, but acute myelofibrosis has rarely been reported as the cause. Metastatic calcification is a constant threat of prolonged hypercalcemia and may be accentuated by therapeutic maneuvers designed to treat the underlying cause. The cardiovascular system is frequently involved and most commonly shows the electrocardiographic changes of prolongation of the P-R interval, shortening of the Q-T interval, and nonspecific T-wave changes. This case illustrates the unusual complication of severe conduction problems secondary to recurrent hypercalcemia and metastatic calcification involving the conduction system.

A 33-YEAR-OLD man presented with severe symptomatic hypercalcemia secondary to acute myelofibrosis. The initial electrocardiogram demonstrated sinus rhythm with a shortened Q-T interval which became normal with return to normocalcemia. Following repeated and prolonged episodes of hypercalcemia, progressive conduction abnormalities developed and persisted. Histologic study of the myocardium at post-mortem revealed extensive calcification and involvement of the conduction system. This case illustrates the acute electrocardiographic changes of severe hypercalcemia and the unusual complication of metastatic calcification involving the conduction system.

Case report

The patient was a 33-year-old Puerto Rican man who had been in good health until one week prior to admission when he developed dull, nonradiating, bilateral chest and abdominal pains. Three days prior to admission the pain increased and was associated with polyuria, polydipsia, constipation, nausea, and occasional vomiting. He denied the use of any medications, including vitamins, or the ingestion of soluble alkali.

The physical examination was unremarkable except for abdominal tenderness without rebound tenderness and mild dehydration. Routine admission laboratory tests were normal except for the screening panel which returned the day after admission with a calcium (Ca) of 14.7 mg per dl and a phosphorus (P) of 3.8 mg per dl. A repeat determination on the second hospital day showed a Ca of 22.5 mg per dl and a P of 3.8 mg per dl. Treatment was initiated with isotonic saline (500-1000 ml per hr) and furosemide, but after 12 hours the Ca was still 17 mg per dl. Intravenous mithramycin (50 μg per kg) was then added to the therapeutic regimen. The patient progressively improved and became asymptomatic and normocalcemic within four days.

The initial electrocardiogram (EKG) (Ca 14.7 mg per dl, P 4.3 mg per dl) showed a sinus rhythm of 66 per minute normal P-R interval and shortened Q-T interval of 0.32 sec (Table 1). Serial EKGs demonstrated progressive normalization as calcium returned to normal without evidence of any problem of atrioventricular conduction.

During subsequent follow-up, the hypercalcemia recurred requiring further saline, furosemide, and mithramycin. Because the etiology of the malignant hypercalcemia remained obscure, a neck exploration was performed on the ninth hospital day. There were no gross or microscopic abnormalities identified in the four parathyroid glands. Postoperatively the serum Ca continued to be elevated and required three additional courses of saline, furosemide, and mithramycin. The renal function, which had been normal on admission, fluctuated throughout the remainder of the patient's hospital course with a creatinine of 1.5 to 2.9 mg per dl.

After review of serial bone marrow studies, a diagnosis of an acute myeloproliferative disorder with rapid evolution was made and treatment initiated with allopurinol and prednisone (120 mg per day). This was followed on the nineteenth hospital day by daily thioguanine (2.5 mg per kg) and cytosine arabinoside (3 mg per kg).

On the morning of the twentieth day the patient became extremely tachypneic, and chest examination re-

Table 1—Serum calcium and electrocardiographic conduction measurements

Day	*Calcium*	*Phosphorus*	*Sinus Rate*	*P-R*	*Q-T*	*Q-at*	*Q-T*22*	*Q-at*23*
1	14.7	4.3	66	0.12	0.32	0.25	0.37	0.29
2	22.5	3.8	60	0.12	0.30	0.24	0.39	0.30
4	9.9	4.7	70	0.12	0.38	0.28	0.36	0.28
19	16.0	5.5	82	0.16	0.30	0.24	0.34	0.27

* Lower limits of normal

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This investigation was supported by the Medical Research Service of the Veterans Administration.

Publication support provided.

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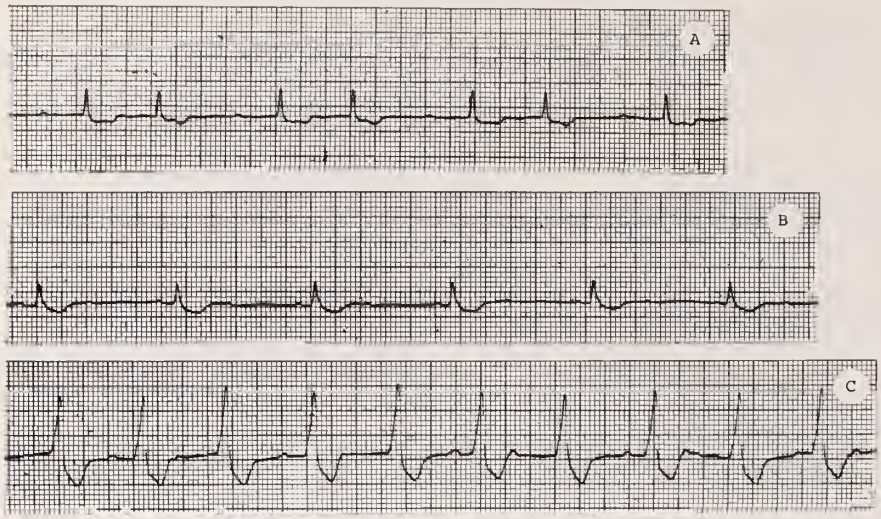

Figure 1—Rhythm strips from twentieth hospital day: (A) 3:2 Wenckebach phenomenon. (B) Complete heart block, precardiac arrest. (C) Accelerated idioventricular rhythms with dissociation, post asystole.

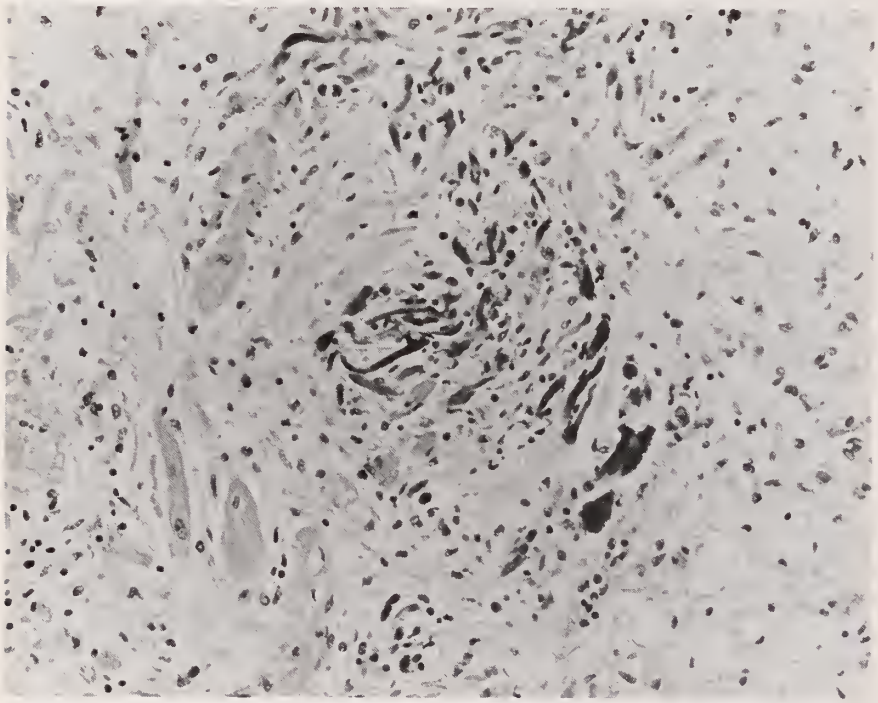

Figure 2—Section of the A-V node demonstrating calcium deposits (black staining granules) within and surrounding node.

vealed bilateral perihilar infiltrations which were not present on the film taken the previous day. The electrocardiogram, which had been stable with normal sinus rhythm (P-R 0.12 sec) and variable Q-T intervals, developed an increased P-R interval of 0.16 sec and frequent premature ventricular contractions. Blood gases which had been normal showed a PaO_2-35 mm Hg, PCO_2-28 mm Hg and a pH of 7.49.

Following endotracheal intubation, 100 percent O_2 and a volume respirator with 10 cm of positive end-expiratory pressure, the PaO_2 improved slightly to 56 mm Hg. Subsequent rhythm strips demonstrated a 3:2 Wenckebach phenomenon, complete heart block (Fig 1A-B) and eventually asystole. After resuscitation only an idioventricular rhythm could be restored (Fig 1C).

The initial right heart pressures, as measured by a Swan-Ganz catheter, were RA-8, RV-35/0, PA-28/4, and Paw-4 mm Hg. The patient developed the picture of shock which was unresponsive to fluid challenge, multiple vasopressor agents, corticosteroids until he died 18 hours following the cardiopulmonary arrest.

Pathology

Antemortem bone marrow examination: The initial clot section demonstrated that the predominant cellular pattern was normal with small focal areas of small immature round cells containing scanty cytoplasm and cleft nuclei. Repeat bone marrow aspirate five days later revealed generalized hyperplasia of both erythroid and myeloid elements with increased numbers of megakaryocytes with no evidence of maturation arrest or immature elements. Reticulum staining was increased in focal areas.

Postmortem examination: The heart appeared normal on gross examination. Microscopic examination showed numerous calcified deposits in the walls of all four cardiac chambers. The myocardial fiber deposits tended to surround blood vessels which were also microscopically involved with focal calcific material (Fig 2). There were extensive calcium deposits in the SA and AV nodes, as well as bundle of His and right and left bundle branches (Fig 3). Occasional polymorphonuclear leukocytes were present surrounding deposits, but there were no other signs of reaction. There was no evidence of coronary artery disease.

Examination of the pleural cavities revealed that each contained approximately 1000 ml of slightly blood-tinged, clear yellow fluid. Both lungs were edematous, firm, and noncrepitant. There was a large amount of nonfrothy yellow fluid which exuded both from lung parenchyma and the tracheobronchial tree. The pulmonary vasculature showed no evidence of thromboembolism. The bronchi, bronchioles, and alveoli were surrounded by polymorphonuclear leukocytes and some of the alveolar spaces were filled with a pink fluid. The alveolar septa, bronchial walls, and small vessels had many focal areas of calcific deposition.

There were microscopic calcific deposits in many other tissues includ-

ing aorta, kidney glomeruli and tubules, urinary bladder, prostate, liver, gastric mucosa, and skeletal muscle. Postmortem bone marrow examination showed hyperplasia of all three main cell lines with a marked increase in reticulum. The bone spicules had a normal appearance except for frequent notching of their margins, reflecting increased osteoclastic activity (Fig 4).

Discussion

The acute effects of hypercalcemia on the electrocardiogram are well known in both experimental and clinical settings. The most commonly reported changes associated with hypercalcemia are shortening of the Q-T interval, prolongation of the P-R interval, and nonspecific T wave changes.[1-5] Prolongation of the P-R interval is the most frequent type of atrioventricular block, but second and third degree atrioventricular blocks have been very infrequently described. Correction of the hypercalcemia has reversed these conduction abnormalities in all instances reported.[1,3,6,7,8,11,12] In the initial electrocardiogram of our patient with a serum Ca of 14.7 mg per dl, the Q-T interval was short (0.32 sec) and nonspecific ST changes were present (Table 1). Both of these abnormalities resolved within 48 hours with the return to normocalcemia. There was no effect on atrioventricular conduction during the initial peak periods of hypercalcemia (Ca 22.5 mg per dl), but with prolonged recurrent hypercalcemia conduction problems did develop and persist despite intensive therapy.

In a general necropsy review of metastatic calcifications by Mulligan,[13] approximately one-third of all cases had some involvement of the myocardium. The deposits were often apparently not quantitatively significant and only rarely associated with arrhythmias. There were no conduction disturbances noted in retrospect. The calcifications were predominantly located in the left atrium and ventricle.

The etiologies or diseases associated with the secondary metastatic myocardial calcifications are extremely diverse[14] and among the most frequently occurring were vitamin D intoxication,[13,15,16,17] hyperparathyroidism,[13,15] uremia,[10,13,18,19] Paget's disease of bone,[20] and bony involvement with tumor.[13,15,21]

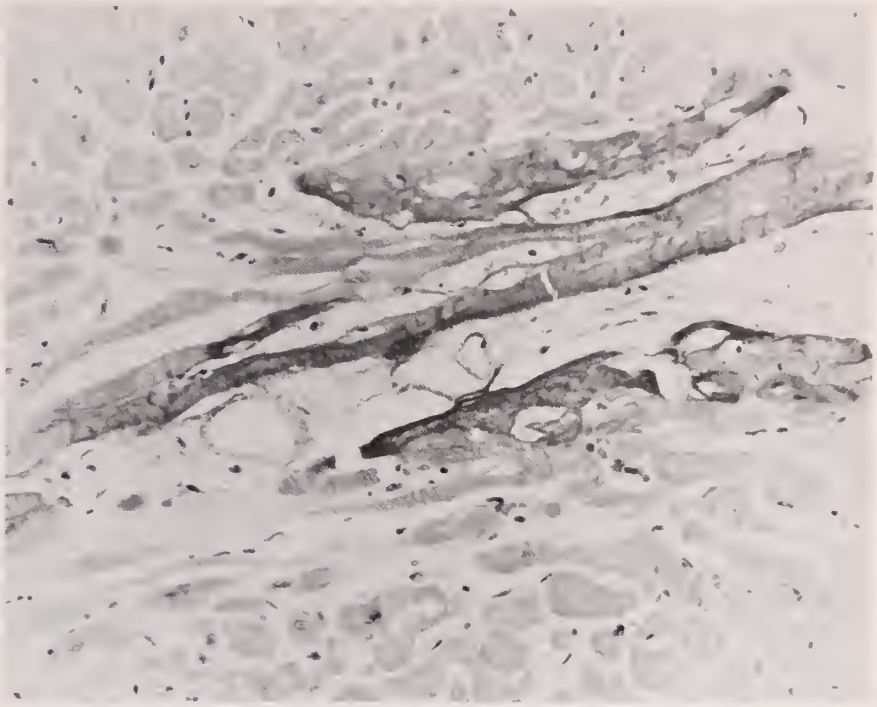

Figure 3—Longitudinal section of the bundle of His with calcium deposits appearing as dark staining granules.

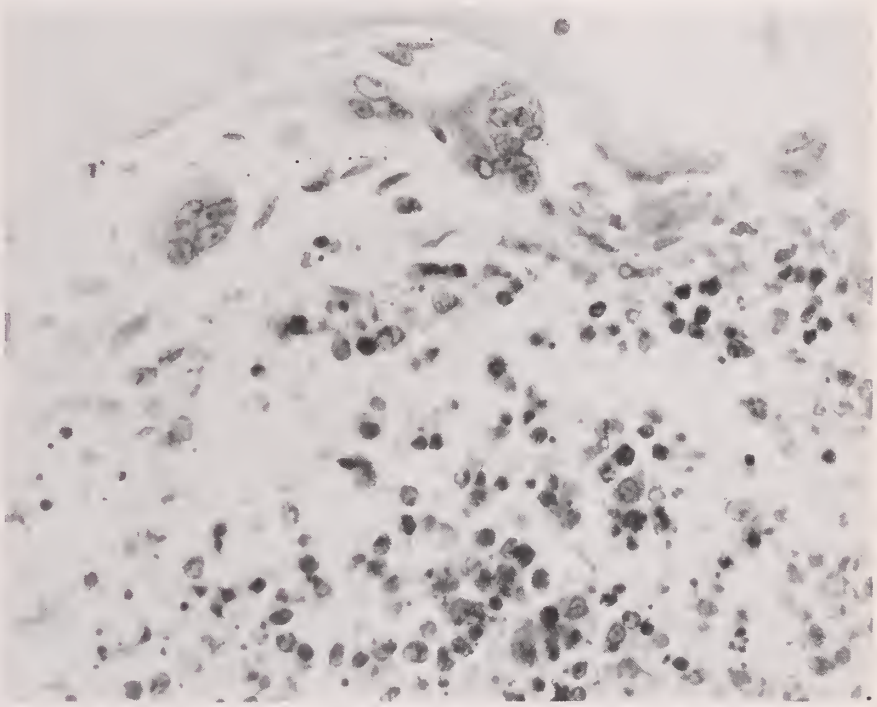

Figure 4—Bone marrow demonstrating a bony spicule. Note the notching of the spicule next to a multinucleated osteoclast.

This report illustrates that an acute myeloproliferative disease may be still another cause of metastatic myocardial calcification. This case illustrates a particularly severe

and prolonged course of hypercalcemia which was not controlled by vigorous therapy and resulted in severe metastatic calcifications.

The extensive calcifications involved most organ systems including renal, gastrointestinal, and pulmonary and were found in the cardiac conduction system. The calcific deposits in the SA and AV nodes, as well as the bundle of His, presumably contributed to the arrhythmias which preceded and followed the cardiac arrest.

If the potentially fatal complication of metastatic myocardial calcification is to be avoided, every effort should be made to control the hypercalcemia promptly with aggressive diagnostic and therapeutic measures. If the course of "malignant" hypercalcemia is prolonged, the potentially preventable complications of metastatic calcifications may significantly alter the prognosis of the basic underlying disease.

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ABSTRACT WISCONSIN AUTHORS

Plasma thyroid-stimulating hormone and thyroxine concentrations in breast cancer

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Cancer 41 (2):666-669, 1978

It has been suggested that breast cancer occurs more frequently in women with a history of thyroid dysfunction than in the general population. Also elevated plasma thyroid-stimulating hormone (TSH) levels have been reported in women with early or advanced breast cancer. To determine whether patients with elevated plasma TSH levels are truly hypothyroid, as judged by their circulating thyroxine (T_4) concentrations, the plasma TSH and thyroxine levels were measured in 74 early breast cancer patients and 53 with advanced disease, 77 with cancer in other organs, and 67 healthy women of similar age. The mean plasma TSH levels were higher in the breast cancer cases than the other two groups, but the difference was only statistically significant in those with advanced disease. Twelve percent of the early breast cancer and 15% of the advanced breast cancer patients had elevated plasma TSH concentrations, compared to only 1% of the other cancer patients and 3% of the controls. Plasma thyroxine levels were similar in all patients, except that four breast cancer patients who had elevated plasma TSH levels also had subnormal plasma thyroxine levels. Seventeen percent of the early breast cancer patients had excessive plasma TSH responses to thyrotropin-releasing hormone. It was concluded that even though a minority of breast cancer patients may have a compensated impairment of thyroid function, it is not likely that this is a significant factor in the etiology of the disease. It has been suggested that the level of circulating thyroid hormone regulates the mammotropic effect of prolactin and that in hypothyroidism increased activity of this hormone may lead to dysplasia and eventual neoplasia. Unless the plasma concentration of thyroxine does not accurately reflect the activity of the hormone in breast tissue, this hypothesis is negated by the finding of normal plasma thyroxine levels in breast cancer. The results also are not consistent with severe pathological abnormalities of the thyroid gland in breast cancer. Plasma triiodothyronine was not measured.

—DOROTHY J BUCHANAN-DAVIDSON, PhD ■

Lethargy as a presentation of infectious mononucleosis

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THE NEUROLOGICAL manifestations of infectious mononucleosis (IM) have been reported in the literature since Dameshek's[1] first documentation in 1931. Controversy arose in 1966 when Schnell et al,[2] in their review of 1,285 patients with IM, reported that none presented with neurological involvement. However, in 1972 Silverstein et al[3] reported on 15 patients with IM who had neurological signs and symptoms as the major and/or heralding features of IM. Although neurological involvement in several series has ranged from 0.7 - 5.5%,[4] incidence of involvement in IM must be far less, considering that most of the series were derived from hospitalized cases.

Case report

A 20-year-old, married, white lumberjack presented to the Rusk County Memorial Hospital because of unresponsiveness of several hours duration. Questioning of the family revealed a nine-day history of mild headache, fatigue, and malaise. The patient continued to work until several days prior to admission, at which time he developed fever and shaking chills.

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On the day of admission, the patient stayed home from work and that afternoon complained of being very tired. That evening the patient became unresponsive and was brought to the Emergency Room.

There was no history of seizure disorder, drug use, pharyngalgia, earache, cough, diarrhea, abdominal pain, dysuria, or head trauma. The patient had been hospitalized twice at the age of 17 for "viral hepatitis" and had "viral illnesses" seven months and one month prior to admission.

Physical examination revealed a strapping, young, white man who appeared very lethargic and who responded only intermittently to loud vocal stimuli. His temperature rectally was 102.8 F. There was questionable nuchal rigidity. There were no skin lesions. There were enlarged left axillary and left supraclavicular lymph nodes. Neurological examination, except for altered sensorium, was within normal limits.

Laboratory studies revealed an hematocrit reading of 46 and a white blood cell count of 3,650 per cu mm with 53% neutrophils, 5% band forms, 2% basophils, 30% lymphocytes and 10% monocytes with adequate platelets. The sedimentation rate was 9 mm/hr, SGOT 61 IU/liter (normal 6 to 26 IU/liter), LDH 800 IU/liter (normal in men 55 to 135 IU/liter), CPK 16 IU/liter (normal 0 to 85 IU/liter), antistreptolysin 0 titer 166 Todd Units (abnormal greater than 166 Todd Units), gamma glutamyl transpeptidase 12 IU/liter (normal in men less than 45 IU/liter), blood urea nitrogen 13 mg/dl, and uric acid 7.7 mg/dl. Urinalysis was within normal limits. The complement level was 66 mg/dl (normal 123 to 167 mg/dl), the aldolase level was within normal limits. Antinuclear antibody and hepatitis B surface antigen were negative. VDRL was nonreactive. Cold agglutinins were negative. Toxic drug screen was negative. Throat culture and stool culture grew normal flora. Urine culture and six blood cultures were negative. Chest x-ray film and electrocardiographic studies were normal. Lumbar puncture on admission, with the patient fully relaxed, revealed an opening pressure of 194 mm H_2O with 2 red blood cells in tube 1 and 1 red blood cell in tube 3 with a cerebrospinal fluid (CSF) total protein of 80 mg/dl and a glucose of 57 mg/dl with a serum glucose of 107 mg/dl. Repeat spinal tap nine days later showed an opening pressure of 145 mm H_2O with 100 red blood cells in tube 1 and 12 red blood cells in tube 3 with a CSF total protein of 78 mg/dl and a glucose of 54 mg/dl with a serum glucose of 91 mg/dl. Viral studies are noted in Table 1.

Within four hours of admission the patient demonstrated a marked improvement in his mental status. He remained alert for the remainder of his hospitalization.

The next day the patient complained of a severe sore throat and multiple white patches were noted. His white blood cell count was 3,888 per cu mm with 18% neutrophils, 20% band forms, 1% eosinophils, 20% monocytes, and 41% lymphocytes, half of the latter being atypical. The patient continued to spike daily fevers to the 101 to 102 F range for the first seven days of hospitalization.

Discussion

Silverstein et al[3] noted normal cerebrospinal fluid (CSF) in four of their five patients. Of the remaining 11 patients, one had only elevated CSF protein. Our patient had CSF protein elevation and

mildly increased CSF pressure. Although this particular combination has not been previously reported, any of the following CSF manifestations, alone or in combination, have been reported in infectious mononucleosis (IM): normal fluid, lymphocytosis, increased protein, increased pressure, all with or without systemic involvement. There is no data on the frequency of CSF abnormalities in patients with IM who do not have signs of central nervous system (CNS) involvement.

The neurological manifestations reported with IM are legion and range from the most common, headache, to the more unusual manifestations, which include psychiatric disorders, meningitis, encephalitis, meningoencephalitis, transverse myelitis, mononeuritis, polyneuritis, cerebellitis, brain stem involvement, peripheral neuritis, cranial nerve palsies, Guillain-Barre syndrone, focal encephalitis simulating herpes simplex encephalitis, cochlear nucleus involvement,[3-8] and possibly subacute sclerosing panencephalitis.[9] Sequelae have included epilepsy, cerebellar dysfunction and isolated paresis, although these are extremely rare.[3]

The features of this case that allowed the patient to be cared for in a 60-bed county hospital without transfer to a tertiary care facility included: (1) rapid improvement of mental status; (2) lack of focal CNS findings; (3) excellent laboratory back-up from both the primary and a tertiary center,* as well as the State Laboratory of Hygiene which conducted CF, HI, and virus isolation studies.

Table I—Viral studies

	Titers			
	12/8/76	*12/15/76*	*12/22/76*	*4/1/77*
Ox Cell Hemolysis Titer	<1/10	1/1280		
Cytomegalovirus Titer		<1/8		
Influenza Type A/PC/1/73	1/16		1/32	
Influenza Type A/SW/1/67	1/16		1/16	
Influenza Type B	<1/8		<1/8	
Adenovirus	<1/8		<1/8	
Parafluenza Type 1	<1/8		<1/8	
Parafluenza Type 2	<1/8		<1/8	
Parafluenza Type 3	1/8		<1/8	
Respiratory Syncytial	<1/8		<1/8	
Measles CF	1/16		1/32	1/32
Measles HI	1/80		1/160	1/80

Mycoplasma culture of throat swab was negative.

Virus isolation studies of spinal serum and throat swab on primary monkey kidney tissue culture, continuous tissue culture cell line, human diploid tissue culture, and mice were all negative.

Finally, this case should serve to reemphasize the dictum of Silverstein et al who in 1972 stated that infectious mononucleosis "should be considered in any acute neurological condition in the young."[3]

*Rusk County Memorial Hospital is on the daily lab route of the Regional Service Laboratory of the Marshfield Clinic.

ACKNOWLEDGMENT: Thanks to Dr Joseph Murphy, Ladysmith, who referred the patient, and to Dr Todd McPherson, Wisconsin State Laboratory of Hygiene, for assistance in performing viral studies.

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ABSTRACT WISCONSIN AUTHOR

Diarrhea and colitis in clindamycin-treated surgical patients

ROBERT E CONDON, MD and MARY JANE ANDERSON, RN, Wood VA Center and Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 113:794-797 (July) 1978

Responding to reports that diarrhea and pseudomembranous colitis occurred relatively frequently among patients who received clindamycin, we initiated a program of surveillance in clindamycin-treated patients, including direct examination of the colon mucosa for inflammation or pseudomembranes and a patient followup by a nurse-epidemiologist. Observation of 145 patients having 161 consecutive clindamycin treatment episodes determined that unexplained diarrhea (two or more stools per day) occurred in 30 patients (21%), and more severe diarrhea (five or more stools per day) occurred in 12 patients (8%). Colitis was not identified at all. The absence of pseudomembranes was confirmed by direct examination of colon mucosa in 114 patients. Development of disabling diarrhea or colitis in association with clindamycin therapy is not a universal phenomenon. ■

Radiation-induced carcinoma of the thyroid with severe thyrotoxicosis

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• A 65-year-old woman who had received radiation therapy to the neck and upper chest at age eight developed severe hyperthyroidism due to metastatic well-differentiated thyroid carcinoma. In previously irradiated patients, hyperthyroidism does not exclude the possibility of thyroid cancer.

THE ASSOCIATION OF carcinoma of the thyroid developing in adult patients with a history of prior irradiation to the head, neck, or upper chest in childhood is now well recognized.[1] Although radiation-induced or associated thyroid carcinomas are generally well-differentiated, hyperthyroidism has not been previously reported in any patient with such a tumor. We have recently studied a patient with previous radiation therapy to the neck and upper chest who presented with severe thyrotoxicosis due to functioning metastatic cancer of the thyroid gland.

Case report

A 65-year-old woman was admitted with a complaint of total dysphagia. There was a history of severe burns to the right arm and anterior aspect of the upper chest and neck at age seven or eight. Shortly after the burns the patient received radiation treatment to the upper chest and neck in an effort to control keloid formation in the scar. No details of the type or dose of radiation employed are available.

The patient had noted a thyroid nodule for many years and had taken thyroxine tablets intermittently. She had taken no thyroid medication for at least three years prior to presentation. During the year immediately prior to presentation, there was a rapid increase in the size of the neck mass; but despite the requests of her family, the patient did not consult a physician. During this year she had severe progressive weight loss (at least 20 lb). Seven days before referral to University Hospitals she developed complete dysphagia with inability to swallow solids or liquids. She was admitted to another hospital where a large cervical mass was noted. A chest radiograph revealed a large soft tissue mass in the neck and multiple lung nodules of varying sizes. In view of the clinical suspicion of hyperthyroidism, a radioiodine uptake was attempted, but the patient was unable to swallow the administered ^{131}I. Open surgical biopsy of the neck mass revealed a mixed follicular and papillary thyroid carcinoma.

Her medical history included a total abdominal hysterectomy and bilateral salpingo-oophorectomy many years previously because of uterine fibroids. She had taken no exogenous estrogens.

At the time of admission to University Hospitals the patient was acutely ill with marked respiratory distress and stridor. She was continually coughing and attempting to manually remove thick secretions from her mouth and throat. Clinical examination revealed generalized weight loss, hyperkinesis, and a fine tremor. There was no proptosis, lid retraction, or lid lag. There was chronic scarring of the right arm, chest and neck, with telangietasia and increased skin pigmentation. A large firm nontender mass occupied the pretracheal area and the left and right sides of the neck. The mass measured at least 10 x 10 cm, although its margins were difficult to assess. The mass formed a firm collar around the trachea which could not be clearly identified. A small surgical scar of recent origin was noted. Despite the generalized cachexia, the breasts were large and firm. There was inspiratory stridor and bilaterally reduced air entry. The pulse was 130 beats per minute, totally irregular. Blood pressure was 180/85 mm Hg and heart sounds were normal. There was no congestive cardiac failure. The rest of the physical examination was unremarkable.

The clinical diagnosis was of a carcinoma of the thyroid gland with extensive local invasion causing tracheal and esophageal obstruction. The hyperkinesis, tremor, and atrial fibrillation suggested hyperthyroidism. Pertinent laboratory data included blood gas analysis demonstrating hypoxemia (paO_2 57 mm Hg) with a low normal $paCO_2$ (35 mm Hg). Thyroid function tests showed evidence of hyperthyroidism: T_3 resin uptake 83% (normal 36-58%); T_4 17 mcg/dl (normal 4.0-11.0); free thyroxine index 13.9 (normal 1.44-6.40).

Because of the relative sparing of the breasts in the presence of generalized cachexia, serum levels of estrogen and prolactin were measured. Blood levels of both estrogen (305 pg/ml; normal 60-250 pg/ml) and prolactin (37 pg/ml; normal 5-15 pg/ml) were elevated. Review of the chest radiograph confirmed the prescence of multiple lung nodules.

The patient was treated with intravenous fluids and a small bore nasogastric tube was passed. Unfortunately the patient would not tolerate this and she removed the tube several times. During the previous hospitalization, the patient had received digoxin without benefit; but following the intravenous administration of propranolol, 1 mg, we observed a significant slowing of the ventricular rate (from 130 to 80 per min), consistent with hyperthyroidism. Twelve hours after admission the patient became more confused, lethargic, and severely cyanosed. Antibiotics were withheld, and she died 24 hours later.

Postmortem examination was performed within two hours of death. The left lobe of the thyroid gland measured 10 x 5 cm with necrotic areas on section. The right lobe of the thyroid also was involved by tumor with invasion of the capsule and

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Figure 1

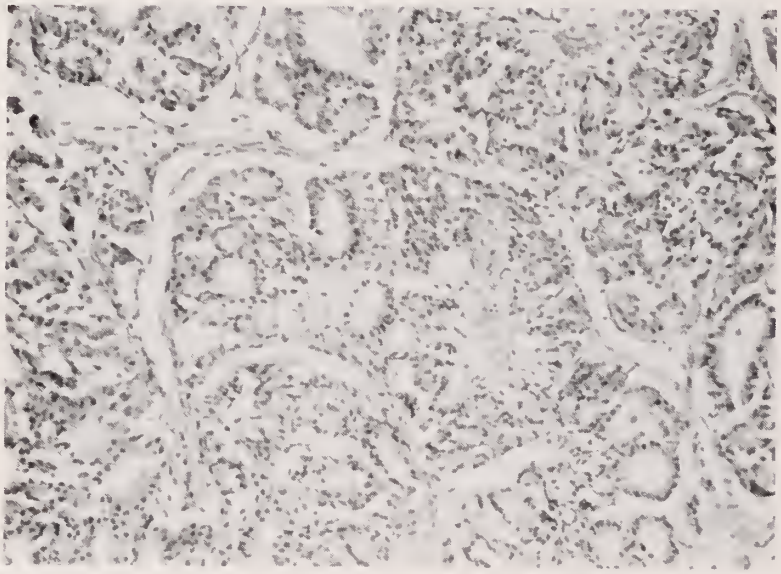

Figure 2

neck muscles. There was severe narrowing of the larynx and trachea due to external compression by the tumor (Fig 1). A left cervical lymph node measured 7 x 6 cm and was full of metastatic tumor. Histology revealed a well-differentiated follicular and papillary carcinoma with colloid present in the follicles (Fig 2). In some areas the tumor was less well-differentiated. Histological examination revealed no evidence of hyperplastic normal thyroid tissue.

The lungs were filled with multiple nodules up to 2 cm in diameter, which were shown to be metastatic thyroid cancer. In addition the left upper lobe showed areas of bronchopneumonia. The pituitary gland was unremarkable.

Comment

The characteristic features of radiation-induced thyroid cancer include a long latent interval between irradiation and the development of the tumor;[2] a well-differentiated histology—generally papillary and follicular carcinoma, with the majority having a papillary component; and a relatively benign clinical course. In many cases the cancer is not clinically apparent and in surgical specimens may be smaller than 1 cm in diameter.[1]

The patient discussed here certainly had a long latent interval, probably about 45 to 50 years, and her tumor was well-differentiated. The case is of interest, however, in view of the clinical and biochemical evidence of hyperthyroidism, which has not been previously reported in patients with radiation-associated thyroid carcinoma.

Hyperthyroidism has been previously reported in nonirradiated patients with well-differentiated thyroid carcinoma, particularly in patients with large masses of metastatic disease,[3] although hyperthyroidism due to a large primary tumor has been reported in a six-year-old girl.[4] In general the clinical manifestations are not prominent, although abnormal radioactive iodine studies and elevations of serum T_3 and T_4 may be demonstrated. On occasion, however, the hyperthyroidism may be severe,[5] and fatal thyrotoxic crisis has been described.[6]

In the present case, because of the patient's terminal state, radioactive iodine studies could not be performed. It is likely, however, that the source of the elevated serum T_3 and T_4 which produced the clinical picture was the large masses of well-differentiated thyroid cancer in the neck and lungs. The concentration of thyroid hormone was not measured in the tumor, but the patient had taken no thyroxine for three years, and the residual normal thyroid tissue was not hyperplastic.

In patients with a history of childhood irradiation to the head, neck or chest, who present with a thyroid nodule or thyroid enlargement, or an abnormal routine thyroid scan, it is important to recall that clinical or biochemical evidence of hyperthyroidism does not exclude the possibility of thyroid cancer. This is particularly important in view of the frequent coexistence in previously irradiated patients of benign thyroid nodules and carcinomas.[1] Even in the presence of clear evidence of hyperthyroidism, a nodular thyroid gland in an irradiated patient is an

indication for surgical exploration to exclude carcinoma.

The elevated serum estrogen and prolactin levels are of interest, particularly in view of the striking breast enlargement. The pituitary gland appeared normal at autopsy and the ovaries had been surgically removed many years previously. The precise significance of the breast enlargement and the elevated hormone levels is not clear at present. Despite the well-differentiated nature of the tumor, ectopic hormone production by tumor cells is possible, especially as a previous report has suggested ectopic production of ACTH by metastatic follicular carcinoma of the thyroid.[6]

ACKNOWLEDGMENT: We are grateful to the referring physician, P R Sholl, MD, of the Riverview Clinic, Janesville, Wisconsin for permission to publish details of this patient.

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Fibromuscular dysplasia of the infratentorial circulation: Discussion of two cases and treatment

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• Two cases of fibromuscular dysplasia of the intracranial portion of the posterior circulation are presented. The most common location of cervical fibromuscular dysplasia is in the external carotid. Intracranial vertebral involvement is rare. Women predominate in this population with a ratio of 9:1.

These two patients presented with visual field loss, dizziness, and other symptoms of vertebral basilar insufficiency. The arteriogram demonstrated fibromuscular dysplasia of both vertebrals in one patient, and an 80 percent stenosis of the right vertebral with complete obstruction of the left vertebral and absence of both posterior communicating arteries was seen in the other.

Previous surgical approaches to this problem have been limited to carotid disease. Progressive dilation with the DeBakey catheter and the microvascular bypass have been used. In our two patients, a microvascular anastomosis of the occipital artery to the posterior inferior cerebellar artery was performed. Both patients were stable in the postoperative period and during the follow-up period. This approach may be useful in managing selected patients with fibromuscular dysplasia of the posterior circulation.

FIBROMUSCULAR DYSPLASIA has been reported in most of the major arteries in the body. The most common location is the renal artery. Extrarenal involvement has been seen in the celiac, mesenteric, iliac, and cerebral arteries. When the cerebral circulation is involved, the most common location is the extracranial portion of the internal carotid artery first reported by Connett and Lansche.[1] Elias[2] reported intracranial carotid disease. An extensive review reported intracranial involvement of 7 of 109 cases of fibromuscular dysplasia of the cervical arteries.[3] Six of these seven were in the carotid distribution. A female sexual predominence of 9:1 is seen in the patients with cervical involvement. Two male patients have been evaluated at St Joseph's Hospital, Marshfield, Wisconsin, since 1975 with fibromuscular dysplasia of the intracranial posterior circulation.

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Publication support provided.

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Case reports

Case 1. A 38-year-old male had a two-month history of nausea, vomit-

ing, and vertiginous discomfort when moving. In September 1975 he had the sudden onset of vertigo and blurred vision. True diplopia was present and marked ataxia with slurring of speech occurred. He had a previous history of hypertension with a diastolic blood pressure between 100 and 120 mm Hg. In September 1975 he was admitted for evaluation of this complaint.

The general neurological examination and screening laboratory studies were normal. He was hypertensive and was placed on hydrochlorothiazide. After discharge, intermittent episodes of vertigo and bilateral leg weakness occurred. In February 1976 an episode of transient left hemiparesis and loss of consciousness occurred and he was readmitted. Again his neurological examination and laboratory studies including EEG and contrast enhanced EMI were normal. Two months later arteriography was performed which revealed proximal beading of the right vertebral artery with narrowing of the left vertebral consistent with fibromuscular dyplasia (Figs 1,2,3). Most of the filling of the infratentorial vessels occurred through small posterior communicating arteries (Fig 4). The vessels were contracted to approximately 10 percent of the normal lumen.

This patient was discharged on a daily therapeutic regimen of 10 gr of aspirin and 100 mg of dipyridamole (Persantine®). Neurosurgical consultation suggested a revascularization procedure. The patient was evaluated subsequently at the Mayo Clinic (Rochester, Minn) in October 1976, and anastomosis of the occipital artery to the caudal right posterior inferior cerebellar artery was performed (Fig 4). On subsequent evaluations at the Mayo Clinic the patient remained stable over six months.

Case 2. A 47-year-old male presented with a six-month complaint of intermittent dizziness and vertigo. He was hypertensive and treated with hydrochlorothiazide. Two months prior to referral he was admitted to another hospital after an episode of nausea, vomiting, severe vertigo, and bilateral leg weakness. His laboratory studies, EEG, and brain scan were normal. Five weeks later he experienced a recurrent episode of nausea associated with severe occipital headache, blurred vision, and double vision. Spinal fluid was normal. His laboratory studies were repeated and found to be normal.

In July 1976 he was referred to the Marshfield Clinic for further evaluation. His examination was normal, and he was normotensive. There were no bruits audible over the head or

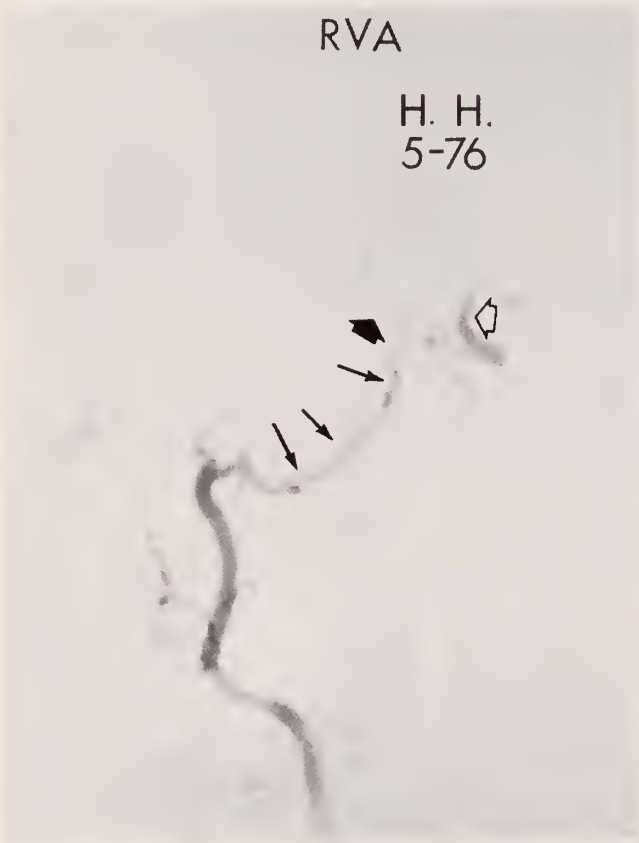

Figure 1—Right vertebral injection, Towne view. Three small arrowheads outline beaded narrowing of distal vertebral; large black arrowhead, right posterior inferior cerebellar artery; large white arrowhead, left posterior inferior cerebellar artery opacified through collateral circulation.

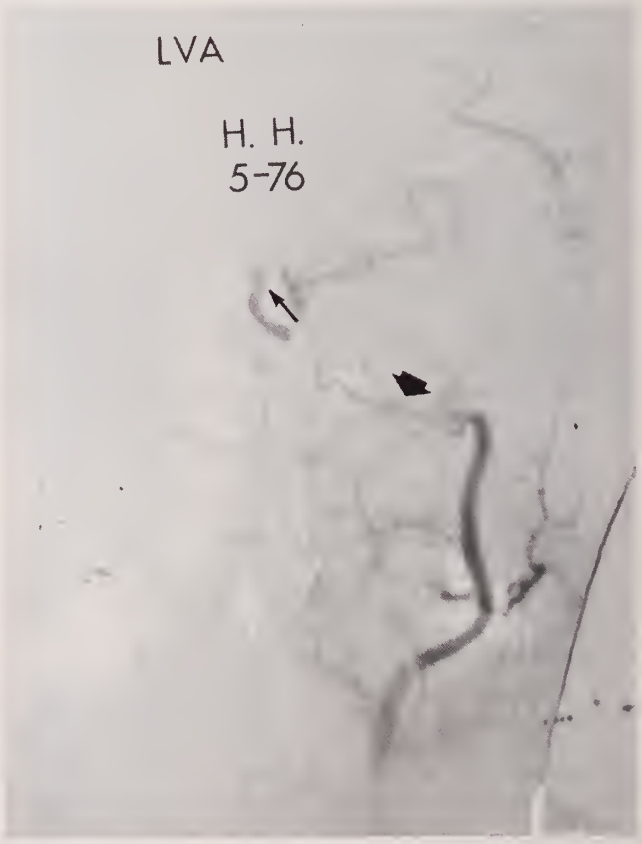

Figure 2—Left vertebral injection, Towne view. Large black arrowhead distal occlusion of left vertebral artery; small black arrowhead posterior inferior cerebellar artery.

neck. His family history was positive for hypertension in three brothers and his father. ENG, audiometry, and a five-hour glucose tolerance test were normal as were other laboratory screening tests. An EMI scan revealed no abnormality.

He returned in September with a report of one episode of right homonomous hemianopsia lasting 10 to 15 minutes. He was admitted to St. Joseph's Hospital for arteriography, and the study revealed beading of the distal intracranial portion of the right vertebral artery with 70 percent narrowing of the proximal basilar artery (Fig 5). The left vertebral artery was absent and no posterior communicating arteries were present on the right. The entire posterior circulation was thus supplied by the limited right vertebral.

While awaiting surgery, he had an episode of confusion, disorientation, and quadriparesis lasting two hours. Heparin was begun and the deficit resolved, leaving residual right hemiparesis and right inferior quadrantanopsia. An attempt to discontinue the heparin was unsuccessful and he again became confused.

Microsurgical revascularization of the right posterior inferior cerebellar artery with the occipital artery was performed (Fig 6). The patient remains stable with no further vascular events over the following 17 months.

Discussion

Fibromuscular dysplasia is a nonatherosclerotic angiopathy of small and medium sized arteries. No specific etiology has been identified, although association with birth control pills has been claimed.[4] No family tendency, relationship to trauma, collagen vascular disease or inflammation has been established. A female preponderance is clearly demonstrated in 85 to 90 percent of the cases of fibromuscular dysplasia and this tendency is seen in patients with the intracranial arterial involvement. Both of our cases were male. The most common site of cervical vessel involvement is the extracranial portion of the carotid while the extracranial vertebral has been reported by Bergan,[5] Sandok,[6] and Morris.[7] Frens,[3] Morris,[7] and Anderson[8] have reported cases involving the intracranial portion of the posterior circulation.

Transient ischemic attacks and cerebral infarctions have been related to this lesion in other patients. Symptoms of vertigo, weakness, headaches, blackout episodes,

Figure 3—Right brachial arteriogram, lateral view. Long arrowhead outlines the occipital artery; short arrowhead on partial occlusion of right vertebral artery.

Figure 4—By permission of Dr T M Sundt Jr: Right brachial arteriogram, lateral view. Large arrowhead faintly filled with vertebral artery. Note most of the filling of the upper basilar arterial system coming through the carotid and posterior communicating artery. Long arrowhead on right proximal occipital artery; small arrowhead showing increase in size of occipital artery with some filling of right posterior inferior cerebellar artery.

Figure 5—Right vertebral arteriogram, Towne view. Arrowhead on 70% stenosis. Note beading of vertebral artery both proximal and distal to the posterior inferior cerebellar artery take off.

Figure 6—Lateral selective external carotid injection. Small arrowhead on proximal occipital artery, increased in size; long arrowheads on proximal and distal recipient vessel.

and focal seizures have been described. An increased incidence of intracranial aneurysms has been reported,[6] and an arteriovenous malformation has been seen in association with fibromuscular dysplasia.[9] Several cases of subarachnoid hemorrhage have occurred. Craniofibromuscular dysplasia has been associated with renal involvement and also in the involvement with other arteries.

The degree of cerebrovascular insufficiency in this condition depends upon the severity of involvement of the individual's vessels and the degree of integrity of the circle of Willis vasculature.

Treatment of the carotid lesion has involved gradual internal dilatation of the extracranial carotid with the DeBakey catheter,[7] anticoagulation,[10] and anastomoses with the extracranial carotid circulation.[11] Sundt, et al[12] have reported the use of the microvascular bypass surgery developed by Yasargil for treatment of the carotid lesions. No previous case of surgical approaches in patients with fibromuscular dysplasia of the posterior circulation have been described. Anastomosis of the occipital artery to the posterior inferior cerebellar artery could lead to extensive anastomotic branches developing over the surface of the cerebellum, providing a bypass route for circulation to the basilar artery. Our two patients stabilized after surgery. One patient was followed for 17 months.

Conclusion

The use of microvascular techniques to revascularize or supplement impaired circulation offers an alternative when clinicians discover the situation of fibromuscular dysplasia of the intracranial posterior circulation. The natural history of this condition is not known, but a report of 76 cases followed for renal lesions showed progression of the old lesion and occasional development of new arterial involvement.[13] It is proposed that this condition is clearly progressive with increasing potential for significant neurological disease. The revascularization procedure in selected patients may be of use in prolonging life and function in a group of patients for which there is no other treatment.

ACKNOWLEDGMENT: The authors wish to thank Dr T M Sundt of the Mayo Clinic for his kind sharing of information on the patient in Case 1 and providing arteriography (Fig 4).

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Multiple pulmonary thromboemboli and pneumothorax

Complications of exogenous estrogen in an alpha-1-antitrypsin deficient woman

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George E Magnin, MD
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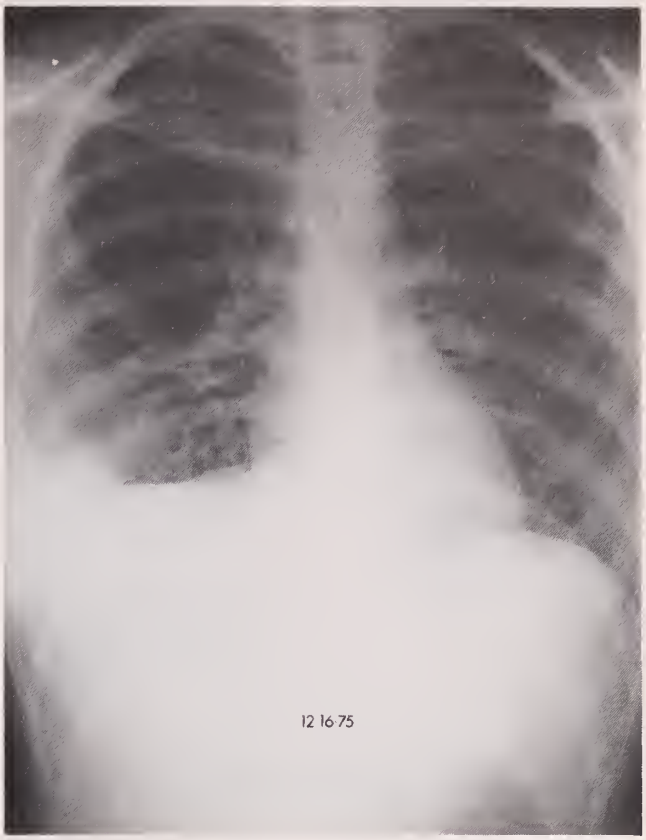
• An 18 year old α_1-antitrypsin deficient female, with exogenous estrogen exposure, experienced multiple pulmonary thromboemboli, complicated by pneumothorax and bronchopleural fistula. Her hospital course included documentation of multiple pulmonary emboli and bronchopleural fistula, anticoagulant therapy, and surgical intervention (dilatation and curettage, lung lobectomy, and ligation of both ovarian veins and the inferior vena cava). In light of some recent new information about α_1-antitrypsin, we speculate that this patient's proteinase inhibitor deficiency contributed to the development of her hypercoagulable state and the complications thereto.

It is of interest that in spite of the relatively frequent separate occurrences of pulmonary embolism and pneumothorax, these two entities are rarely associated with one another. We have recently observed a previously healthy young woman with homozygous α_1 antitrypsin (α_1-proteinase inhibitor) deficiency who, when exposed to exogenous estrogen, developed life-threatening thromboemboli, complicated by pneumothorax and bronchopleural fistula. This communication presents the treatment and complications of this patient and raises the question of the possible role of α_1-antitrypsin in preventing the hypercoagulable state. We are unaware of any previous such report in the literature.



Figures 1 and 2—Chest roentgenograms consistent with multiple pulmonary thromboemboli.

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This paper was presented, in part, at the Wisconsin Thoracic Society meeting in Milwaukee, Wisconsin, April 23, 1977.
Publication support provided.
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Figure 3—Admission chest roentgenogram exhibiting pneumothorax.

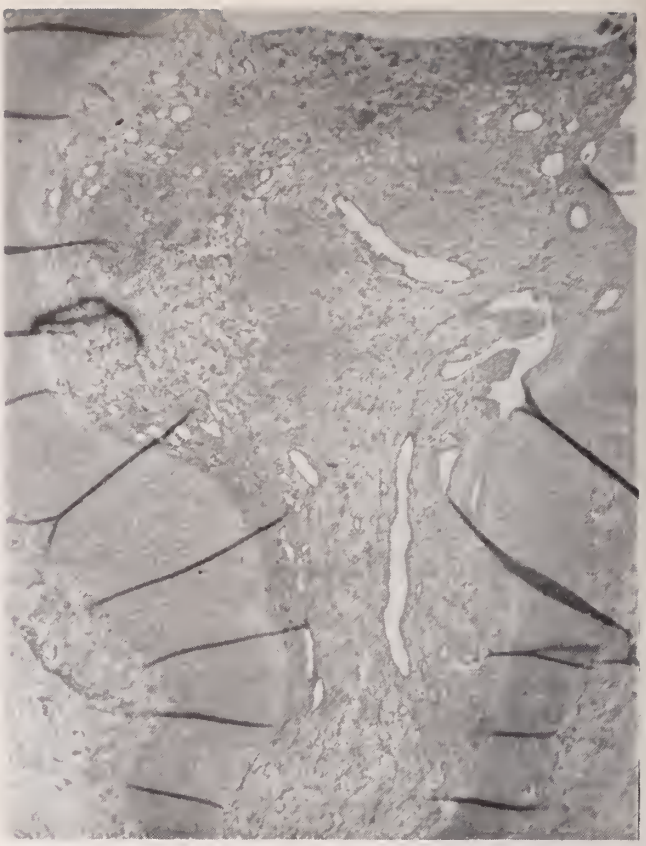

Figure 5—Photomicrograph depicting the thromboembolic occlusion of the mainstem artery of the left lower lobe (hematoxylin eosin, ×4).

Figures 4 and 6—Pulmonary arteriograms demonstrating multiple pulmonary thromboemboli. The arrows depict new areas of decreased perfusion on June 15, 1976.

Case report

An 18-year-old white woman, who had been using birth control pills (ethynodiol diacetate with ethinyl estradiol: Demulen®-21) from November 1975 to March 1976, noted pleuritic pain in her right chest in December 1975. She was seen by her local physician who obtained a chest roentgenogram (Fig 1) showing a right-sided pulmonary infiltrate and pleural effusion. She was treated with antibiotics with some temporary relief. However, she continued to have periodic episodes of breathlessness and sharp pain in the left side of her chest. This caused her to return to her physician in March 1976, when the roentgenogram of Fig 2 was obtained. The infiltrate was then on the left side with pleural effusion present. She was treated with antibiotics and gamma globulin. She persisted with breathlessness, a productive cough, and left upper back and chest pain. She was referred to the Marshfield Clinic in May 1976. Additional information included a strong family history of thrombophlebitis during pregnancy with both her mother and grandmother experiencing this. Physical examination revealed moderate respiratory difficulty, tachycardia, and normal blood pressure. The left side of the chest was enlarged to inspection, had increased resonance to percussion, and decreased breath sounds to auscultation. A pelvic examination disclosed a slightly enlarged uterus and left ovary. A chest roentgenogram (Fig 3) showed left pneumothorax (she at no time had a thoracentesis prior to admission to St Joseph's Hospital in Marshfield). A pregnancy test was negative at the time of admission. Other laboratory data included an IgG decreased to 520 mg per 100 ml (normal value 900-1500), an IgA of 50 mg per 100 ml (170-410), and an IgM of 165 mg per 100 ml (50-110). An α_1-antitrypsin level was 76 mg per 100 ml (180-240). Phenotype by electrophoresis later disclosed a ZZ pattern. Following admission, a tube inserted through the left side of the chest wall resulted in upper lung expansion. The left lower lobe remained partially collapsed with a slowly developing air-fluid level. Venograms showed no thrombi in the iliac and lower extremity vessels. Skin tests for tuberculosis, Candida, and histoplasmosis were negative. One week after admission the patient had a hypotensive episode after experiencing chest pain and vomiting. She was dyspneic with blood gas determination of hypoxia, hypocarbia, and alkalosis. An electrocardiogram showed T-wave inversion in standard lead 3 and precordial lead V-2. Angiography showed a large saddle embolism in the right main pulmonary artery and total left lower lobe arterial occlusion (Fig 4). Pulmonary artery pressure was 50/25 mmHg. A positive pregnancy test had been obtained before the angiogram was performed. Sodium heparin therapy was instituted with a dose of 36,000 units per 24 hours necessary to maintain an activated partial thromboplastin time in the therapeutic range (50-80 seconds). After another week the patient experienced an incomplete spontaneous abortion requiring a dilatation and curettage procedure. Repeat roentgenograms showed a persistent air-fluid level involving the left pleural space. Bronchography revealed evidence of bronchopleural fistula. Two weeks after the D and C a left lower lobectomy of the lung was performed. Histology was consistent with main stem artery occlusion (Fig 5). On the first postoperative day, she again had dyspnea, hypotension, tachycardia and diaphoresis. Blood gases again showed marked hypoxia, hypocarbia and alkalosis. A pulmonary angiogram revealed evidence of further embolic phenomena (Fig 6), especially in the right lower lobe and the left upper lobe areas, and pulmonary artery pressure was 53/10 mmHg. The next day the patient's inferior vena cava and both ovarian veins were ligated. She was discharged 10 days later. Subsequent left leg phlebitis necessitated a three-month course of warfarin sodium therapy with no subsequent recurrence. When last seen nine months after surgery, the post-thoracotomy chest roentgenogram was essentially normal and the patient was asymptomatic.

Comment

Blundell's[1] review of the literature in 1967 revealed only 10 documented cases of pneumothorax associated with pulmonary infarction. His postulated mechanism for the pneumothorax was that of rupture of the pleural surface of the necrotic infarction and communication between respiratory passages and the pleural cavity. Mundth, Folley and Austen[2] had previously presented three cases of pneumothorax as a complication of positive pressure respiratory assistance in patients with pulmonary infarction and infection, but these were not included in Blundell's review. In these cases it was speculated that the necrosis produced by the infection was necessary for this phenomenon to occur.

The role of α_1-antitrypsin in emphysematous bleb formation is well documented, but pneumothorax is seldom seen in young, previously asymptomatic patients with this deficiency.[3] Thromboembolic phenomena have been associated with the use of oral contraceptives and pregnancy.[4] A recent article by Carvalho, et al[5] proposes that the major mechanism of action is related to accelerated intravascular coagulation and an inappropriately low fibrinolytic response. Levels of antithrombin-III were not found to be significantly altered in that and other studies.[6] However, recent evidence that α_1-antitrypsin plays a major role in coagulation would be supported by our patient. Lane, et al[7] have found that the anticlotting activity of α_1-antitrypsin is approximately 50% that of antithrombin-III. In addition, Matheson and Travis[8] have recently presented convincing evidence that α_1-antitrypsin has an inhibitory effect upon the clotting and esterase activities of thrombin. The patient's antithrombin-III levels were normal and α_1-antitrypsin levels markedly diminished. In normal individuals estrogen has been shown to significantly increase the levels of α_1-antitrypsin.[3] Thus, it might be postulated that the function of α_1-antitrypsin includes prevention of hypercoagulability in estrogen-rich states by inhibiting the action of thrombin in clot formation. This concept receives further clinical support by the mother's and grandmother's problems with thrombophlebitis during pregnancy. We found that the mother's α_1-antitrypsin level was diminished to 149 mg per 100 ml and her phenotype was MZ. The patient's grandparents and father are deceased preventing any further family study.

Summary

We report a case of a young female with multiple pulmonary thromboemboli probably associated with the use of estrogen-containing compounds and pregnancy, who experienced pneumothorax and bronchopleural fistula. The patient's α_1-antitrypsin deficiency may have significantly influenced her coagulation mechanism, facilitating this sequence of events. We speculate that α_1-antitrypsin plays a heretofore unappreciated role in preventing the hypercoagulable state.

ACKNOWLEDGMENT: We thank Dr Fred Kueppers, Rochester, Minnesota for phenotyping.

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COMMENTS ON TREATMENT

Co-Editor: **CHARLES L JUNKERMAN, MD, Professor of Medicine, Medical College of Wisconsin, Milwaukee**

Disopyramide (Norpace®)

Ronald Siegel, MD, Milwaukee, Wisconsin

DISOPYRAMIDE (Norpace®) is the latest antiarrhythmic drug approved by the Food and Drug Administration for clinical use. Its antiarrhythmic properties were first described by Mohler and Van Arman in 1962. Since that time the drug has been subjected to extensive experimental and clinical testing. Disopyramide (DP) has been commercially available in Europe as Rhythmodan since 1970 and has been under clinical investigation in the United States since 1965. The Searle Company manufactures the drug as the phosphate salt.

Electrophysiology

DP, although structurally unrelated to quinidine and procainamide, has electrophysiologic properties similar to these two drugs and is therefore considered a Type I antiarrhythmic drug. The antiarrhythmic properties of DP are related to its effect on the action potential of myocardial cells and pacemaker tissue. Like other Type I antiarrhythmic drugs, it suppresses automaticity by decreasing spontaneous diastolic depolarization (Phase 4). It also slows conduction velocity by decreasing the rate of rise of the myocardial cell action potential (Phase 0) and increases the effective refractory period by prolonging repolarization (Phase 3). As a result of decreasing conduction velocity and increasing the effective refractory period, DP suppresses reentrant arrhythmias by converting a unidirectional block into a bidirectional block incapable of reentry. Therefore, DP appears to be effective in arrhythmias related to increased automaticity or a reentry phenomena. DP also has been found to prolong conduction time and prolong the effective refractory period of accessory pathways in patients with the Wolff-Parkinson-White syndrome.

Early intracardiac electrophysiologic investigations using bundle of His studies demonstrated no significant effect on AV conduction (AH interval) or His-Purkinje conduction (HV interval). These preliminary studies did demonstrate a reduction in sinus node recovery time. In a subsequent study, however, in patients with clinically suspected sick sinus syndrome, DP significantly depressed sinus node recovery time. Studies on refractoriness have shown an increase in the atrial effective refractory period and either no change or slight prolongation of the effective and functional refractory periods of the AV node and His-Purkinje system. DP effect on the scalar electrocardiogram has been variable. Most studies have shown no significant changes in sinus rate, or PR interval, and a slight increase in QRS and QT intervals.

Hemodynamics

Little information is available regarding the hemodynamic effects

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of DP in humans. Befeler and Willis studied the hemodynamic effect of intravenous DP in patients with normal and impaired left ventricular function. These studies demonstrated a slight decrease in cardiac output and an increase in systemic vascular resistance. These changes appear to be related to a mild negative inotropic property of the drug and a reflex increase in systemic resistance and are not felt to be clinically significant.

Pharmacology

DP is rapidly and almost completely absorbed from the intestine, reaching a peak plasma level from 1/2 to 3 hours after an oral dose. Its plasma half life is 6 to 7 hours after an oral dose. When given intravenously, the half life is approximately 2 hours. The bioavailability of an oral dose is 60% of the intravenously administered drug. Fifty percent of the drug is excreted unchanged in the urine while 30% is metabolized by the liver and excreted in the urine as metabolites. The major metabolite is an N-dealkylated form and has less than 50% the antiarrhythmic activity of the parent compound. Unlike quinidine and procainamide, urinary pH does not appear to influence excretion of the drug or its metabolites. Therapeutic plasma levels have been shown to be between 2 to 4 mcg per ml while toxic levels have not been well defined in humans.

Clinical trials

Numerous experimental and clinical studies have been performed demonstrating the efficacy of DP on suppression of both supraventricular and ventricular tachyarrhythmias. Initial studies done in animals demonstrated the antiarrhythmic properties of DP exceeded that of quinidine and procainamide. These studies were carried out in dogs in which atrial tachyarrhythmias were induced by acontine and ventricular premature beats were induced by either ouabaine toxicity, catecholamine stimulation, or coronary artery ligation.

The first major United States clinical study involved 120 patients with a variety of supraventricular and ventricular arrhythmias documented on nine-hour Holter recordings. This study compared the effect of DP to a placebo. Seventy-six of these patients were grouped as having 60 or more premature ventricular beats per hour. DP reduced the median number of premature ventricular beats from 170 per hour to 35 per hour which was significantly lower than the placebo periods. Six patients with ventricular tachycardia during the placebo period had no such arrhythmia during DP therapy. In this study, DP was effective in patients with a history of a previous myocardial infarction. There were no adverse effects when patients also were receiving digitalis for control of congestive heart failure.

Another major US investigation was a double blind study comparing the efficacy of DP (150 mg every six hours) to quinidine (325 mg every six hours). The study included 124 patients who qualified for the study by having at least 60 premature ventricular beats per hour documented by nine-hour Holter recordings. Sixty-two patients were randomly assigned to DP therapy and 62 were assigned to quinidine therapy. Both drugs resulted in a significant reduction of ectopic beats; however, there was no significant difference between the two drugs in the quantitative reduction. Five percent of patients taking quinidine and 12% of patients taking DP demonstrated an increase in ectopic ventricular beats by at least 75%. During the study period, 36% of patients taking quinidine were forced to drop from the study because of significant quinidine related side effects. Only 8% of patients taking DP had to discontinue therapy because of side effects. Thus, DP was as effective as quinidine in reducing premature ventricular beats with a much lower incidence of side effects.

DP has been used successfully in patients with refractory ventricular tachycardia, unresponsive to both conventional antiarrhythmic drugs and other investigational drugs such as aprindine, tocainide and mexiletine. In these patients, DP was administered intravenously. Two recent studies have demonstrated the prophylactic benefit of oral DP in suppressing ventricular premature beats after acute myocardial infarction.

Rosen recently demonstrated that DP was moderately effective in the treatment of a variety of supraventricular arrhythmias. Conversion to sinus rhythm was successful in 38% of patients with atrial flutter, 20% of patients with atrial fibrillation and one of three patients with paroxysmal atrial tachycardia. In this study DP was given intravenously. DP also has been found to be useful in the maintenance of sinus rhythm following electrical cardioversion. Although the electrophysiologic effects on aberrant pathways suggest DP may be useful in the treatment of certain arrhythmias in the W-P-W syndrome, no clinical trials are yet available.

Indications

DP is indicated for the treatment of ventricular ectopic activity. This includes unifocal and multifocal ventricular premature beats as well as salvos or couplets of premature ventricular beats. Further studies regarding its use in acute myocardial infarction is needed. There is no evidence that DP or any other antiarrhythmic drug is of value in the prevention of sudden death from ventricular arrhythmias. Although there is evidence that DP is moderately effective in the treatment of certain supraventricular arrhythmias, further study is needed regarding its use in suppression of these rhythm disturbances.

Dosage and administration

At the present time, DP is commercially available in the United States as tablet form only in 100 mg and 150 mg tablets. The recommended adult dosage is 400 to 800 mg per day in four divided doses. A small number of patients with refractory ventricular arrhythmias have required and tolerated up to

1600 mg per day resulting in serum levels up to 9 mcg per ml. The dose of DP must be adjusted with respect to the patient's size and renal function.

When rapid control of ventricular arrhythmias is indicated, a loading dose of 300 mg should be given followed by 150-mg doses every 6 hours. For patients weighing less than 110 lb, the recommended loading dose is 200 mg followed by 100 mg every six hours. Therapeutic effects are usually seen within 30 minutes to three hours after the loading dose. If there is no response after six hours, then 200 mg every six hours (150 mg for patients less than 110 lb) may be tried. It is essential that patients requiring higher than standard doses be continually monitored during therapy. When there is no need for rapid control, the maintenance dose should be started without a loading dose. This will reduce the side effects which are more common when a loading dose is used.

In patients with moderate renal insufficiency having creatinine clearances greater than 40 ml per min, 100 mg every six hours is recommended with a loading dose of 200 mg if indicated. In patients with more severe renal insufficiency, the following dose regimen is recommended:

CREATININE CLEARANCE (ml/min)	DOSE (100 mg)
15-40	Every 10 hr
5-15	Every 20 hr
1-5	Every 30 hr

When transferring a patient to DP from another Type I antiarrhythmic drug, the maintenance dose of DP should be started 6 to 12 hours after the last dose of quinidine or 3 to 6 hours after the last dose of procainamide.

Adverse effects

Adverse reactions of DP are related to its cardiac effects and its anticholinergic effects. While there does not appear to be significant myocardial depressant effects, it must be used cautiously in patients with significant impairment of left ventricular function and in patients with acute myocardial infarction. Although electrophysiologic studies have shown no significant changes in AH or HV intervals, the drug must be used cautiously in patients with preexisting conduction defects on the scalar electrocardiogram. Anticholinergic side effects include nausea, blurred vision, dryness of mouth and eyes, and urinary retention. Therefore, it should not be used in patients with glaucoma or urinary retention unless specific measures are taken to avoid exacerbation of these problems.

Summary

Disopyramide (Norpace®) (DP) is a new oral antiarrhythmic agent with electrophysiologic properties and antiarrhythmic efficacy similar to quinidine and procainamide. Its major indications at the present time are in the management of various ventricular arrhythmias. A major advantage over presently available antiarrhythmic drugs is a low incidence of both cardiac and systemic side effects. As with other antiarrhythmic agents, there is no evidence that DP is effective in prevention of sudden death from ventricular arrhythmias. ■

ABSTRACTS WISCONSIN AUTHORS

Ruptured Baker's cyst simulating acute thrombophlebitis

RAPHAEL F KILCOYNE, MD; THOMAS J IMRAY, MD; and EDWARD T STEWART, MD, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 240:1517-1518 (Sept 29) 1978

POPLITEAL SYNOVIAL CYSTS (Baker's cysts) commonly occur in patients with a chronic knee-joint effusion whether related to trauma, degenerative change, or an inflammatory process. Ruptured cysts that dissect into the calf can produce severe pain that simulates thrombophlebitis. Arthrography is a useful tool for diagnosing extrameniscal lesions of the knee joint. The authors reported three patients with ruptured Baker's cysts initially suspected of having thrombophlebitis. Each complained of pain and swelling in the calf, ankle or knee. None had a history of rheumatoid arthritis or meniscal cartilage tear. In each instance, arthrography was delayed because of a failure to recognize the existence of a knee-joint problem.

Radiation-related thyroid carcinoma

JAMES M CERLETTY, MD; ALEJANDRO R GUANSING, MD; NORMAN H ENGBRING, MD; THAD C HAGEN, MD; HAK-JOONG KIM, MD; KAUP R SHETTY, MD; PAUL S ROSENFELD, MD; and STUART WILSON, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 113:1072-1076 (Sept) 1978

OF 1,825 SUBJECTS WITH A history of head or neck irradiation, 358 (19.6%) were found to have thyroid abnormalities. One hundred sixty-five (9%) had either single or multiple nodules, 153 (8.4%) had diffuse thyromegaly, and 40 (2.2%) had had thyroid surgery. Surgery was performed on 113 subjects with nodules; carcinoma was found in 34 (30.1%). Clinical examination of the neck was the most valuable method of detecting abnormalities. Detection of nodules was not significantly enhanced by routine use of thyroid imaging studies. Measurements of levels of serum thyroid-stimulating hormone, thyroxine, triidothyronine resin uptake, and thyroid antibodies were not useful in screening for nodules or carcinoma.

Scientific Medicine

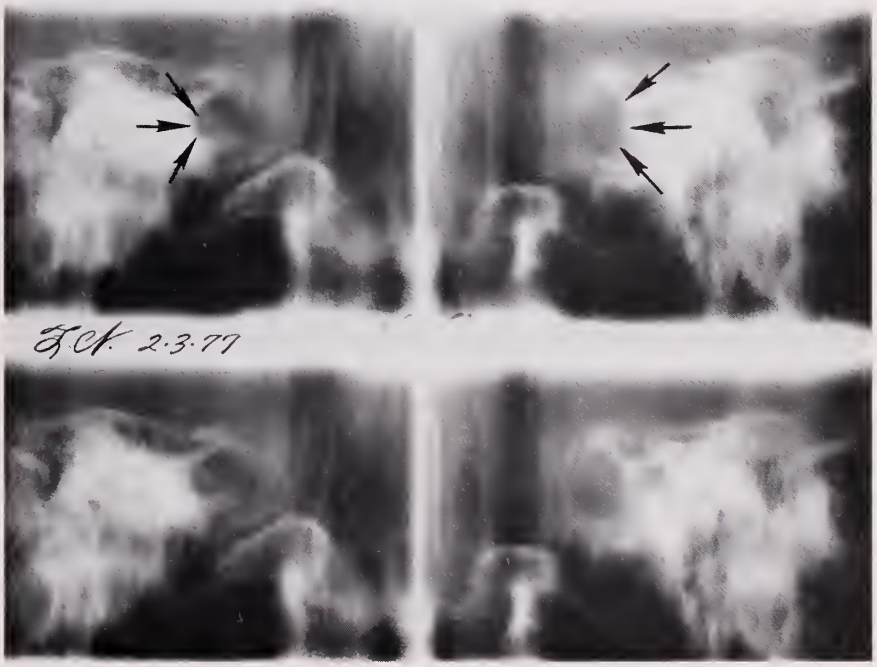
Evaluation and treatment of small acoustic schwannomas

Marc A Letellier, MD
Phillip M Green, MD
Richard Strand, MS
Marshfield, Wisconsin

ACOUSTIC SCHWANNOMAS have been recognized as a pathological entity for several hundred years. In the early 1900s, operative mortality and morbidity were quite high and surgical intervention with attempts at total resection resulted in a mortality rate of 80%. These rates were subsequently reduced to 20% with Harvey Cushing's techniques, but he frequently settled for partial removal. In the past two decades, remarkable advances in instrumentation and micro-surgical techniques have lowered the mortality figures to below 5%. House and Hitzelberger[1] have shown that it is possible to discover these tumors in their intracanalicular stage and remove them without significant morbidity. However, the method they advocated, the translabyrinthine approach, almost invariably destroys hearing. Audiometric parameters,[2,3,4,5] the ENG,[6] and brain stem evoked responses[7] have been reported to be helpful in detecting acoustic schwannomas as have internal auditory canal radiographs[8] and the CAT scan.[9] Pantopaque cisternography was suggested to be the most useful single test in a satisfactorily screened population.[10]

From September 1976 to August 1977, 16 patients who were at risk for acoustic schwannomas were evaluated. Two patients were found to have very large tumors, 4-5 cm in diameter and six of these pa-

Figure 1—Typical abnormal tomogram showing enlarged and shortened canal. More spread out arrows.



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Publication support provided.

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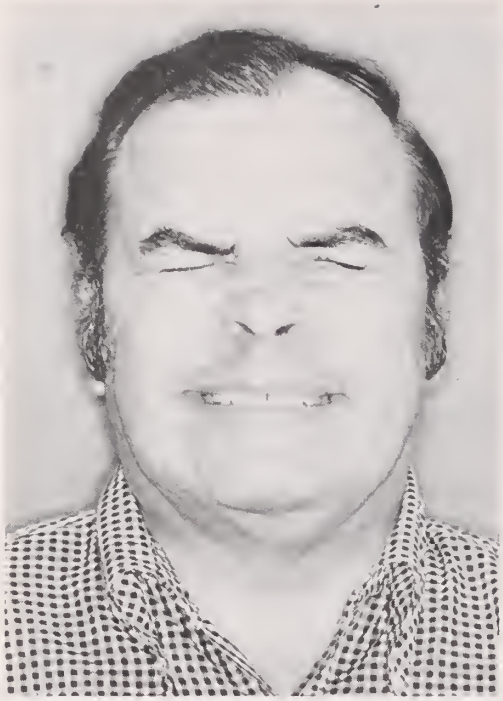

Figure 2—Excellent facial function two weeks postoperatively.

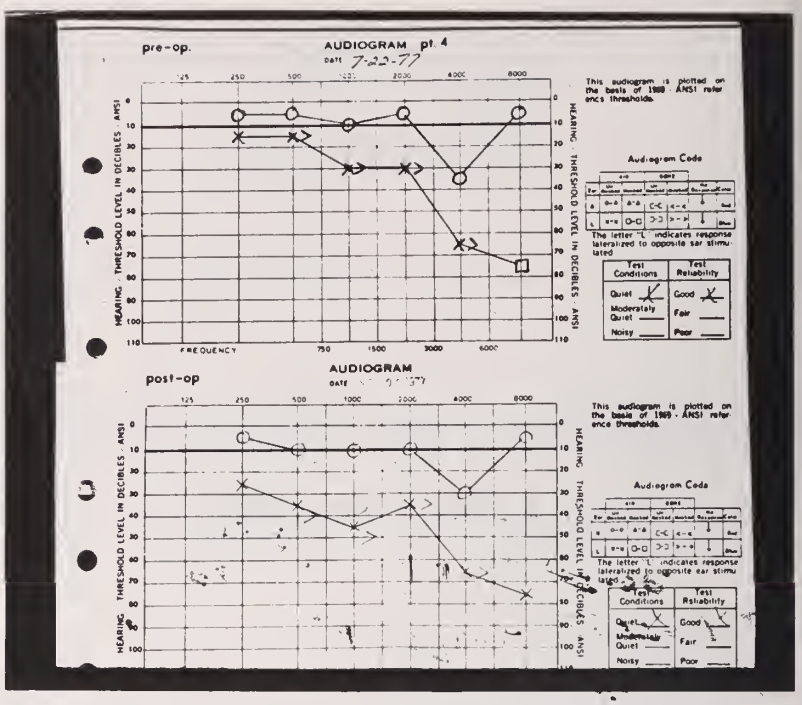

Figure 3—Above, audiogram shows decreased left hearing. Below, audiogram postoperatively shows preserved hearing.

Figure 4—Although read as equivocal, this study outlined very well a small cerebellar pontine angle lesion. Black arrows.

tients had small tumors ranging between 1-2 cm. Only one patient had previously been seen at the Marshfield Clinic with a tumor of this size. Fourteen patients were evaluated in the manner indicated in the next paragraph.

Audiologic testing consisted of pure tone audiometry, speech discrimination, SI-SI, tone decay, and stapedial reflex decay. Electronystagmography and CAT scanning were performed in 13 cases. All patients had tomography of the internal auditory meatus (Fig 1). Pantopaque cisternography resolved the diagnosis in each case and there were no negative explorations. The patients who were found to have cerebellopontine angle space occupying lesions by the above methods of investigation underwent a modified suboccipital approach. This was a combination of the Malis and Yasargil operative procedures.[11,12] The surgical microscope with micro-instrumentation and micro-techniques was used in every case.

Case reports

The two following cases are representative of our experience with small acoustic schwannomas.

Case 1. This 44-year-old male executive first noticed a progressive onset of hearing loss when using the telephone. The hearing loss was accompanied by tinnitus without any other neurological symptoms. Internal auditory canal tomograms revealed left-sided changes corresponding to his left-sided hearing loss and the patient was referred to the neuro-otologist for further evaluation. Audiometric examination revealed a left high tone sensory neural loss of a moderate to severe degree with a decreased SI-SI,

positive tone decay, decreased speech discrimination and normal stapedial reflex. The ENG was normal. Routine CAT scan studies were normal. The patient was admitted to the hospital for further evaluation. The angiogram was normal and pantopaque cisternography was positive revealing the outlines of a small left cerebellar pontine angle mass. At surgery, a small tumor of approximately 1 to 1.2 cm was dissected free of the cochlear vestibular and facial nerve. The postoperative period was uneventful and facial, cochlear, and vestibular functions were preserved (Fig 2,3).

Case 2. This 40-year-old female presented in 1975 with a progressive onset of hearing loss on the right side of 1½ years duration. Audiometry revealed decreased speech discrimination, positive tone decay, and a right sensory neural loss for high tones of a moderate degree. The electronystagmogram and internal auditory canal tomograms were positive on the right side. The CAT scan was negative and a pantopaque study was equivocal (Fig 4) according to the treating physicians. Some five months later, the patient was readmitted for a repeat study which was officially read as negative. On routine follow-up six months later, the x-ray films were reviewed by one of us (ML) and were interpreted as being positive both times. However, audiometry showed marked improvement in the sensory neural loss with disappearance of the tone decay and normal speech discrimination. Because of the treating physicians impression of the presence of a tumor on the previous pantopaque studies, a third cisternogram was ordered. This revealed a 2 cm cerebellar pontine angle mass on the right side. A suboccipital craniotomy was performed and the facial nerve was preserved with total removal of acoustic schwannoma. The postoperative period was uneventful and a progressive return of facial function was observed over a period of several months. No hearing was preserved in this case.

Table 1—Patients with positive pantopaque study

HISTORY	No. 1	No. 2	No. 3	No. 4	No. 5
Age	65	47	38	44	54
Sex	Female	Male	Male	Male	Male
VIII Loss	3 yr.	10 yr.	19 yr.	2 yr.	10 yr.
Tinnitus	+	+	+10 yr.	+2 yr.	+
Facial Numbness	+		+2 mo.		
AUDIOLOGY					
Speech Discrimination	↓40% R	↓R	↓L	↓L	↓L
SISSI	N	↓	↓	↓	↓
Tone Decay	No	No	No	Yes	No
Sensory-Neural	Mod.↓	Mild-Mod.	Mild-Severe	Mod.-Severe	Severe
Stap Reflex Decay	NT	+	+	Normal	NT
ENG	Weak R	Normal	Not Done	Normal	Weak L
RADIOLOGY					
Tomograms	4 mm	5 mm	4 mm	2 mm	Tmpt. 4 mm
CAT	Neg.	Neg.	+	Neg.	+
Angiography	+	+	+	Neg.	Neg.
Pantopaque	+	+	+	+	+

Discussion

Acoustic schwannomas account for between 8% and 10% of all brain tumors. They occur most commonly between the 4th and 5th decade of life, rarely being seen in the very young. The lesion may remain asymptomatic for years or even a lifetime. In two-thirds of the cases reviewed in the literature, a schwannoma is initially located on the vestibular portion of the 8th nerve within the internal auditory canal; however, some acoustic schwannomas arise medial to the porous acousticus. The 7th and 8th cranial nerves and blood vessels in the canal are mechanically displaced by the tumor or ultimately flattened against the canal walls. The canal is widened or eroded by the expanding tumor, a portion of which spills out eventually into the porous and into the cerebellar pontine angle. The cerebellar pontine angle lesion enlarges to compress cranial nerves 5 and 6 in the anterior medial direction and 9, 10, and 11 in the inferior direction. As it encroaches upon the cerebellum and the brain stem, it also compromises cerebral spinal fluid circulation. In our series (Table 1 and Case 2), the patient's symptoms existed for 1½ to 19 years prior to evaluation. All patients who subsequently had tumors demonstrated decreased hearing. Five patients had tinnitus. One patient had unsteadiness but she also had multiple meningiomas. One patient had facial paresthesias in the distribution of the 5th cranial nerve. No other neurological complaints were noted by history and no neurological findings were present on examination in our six patients with small acoustic schwannomas. Pure tone audiometry was positive in each patient demonstrating a moderate to severe asymmetrical hearing loss. Speech discrimination was impaired in all six patients. Tone decay was present on two of six and reflex decay was present on two of three

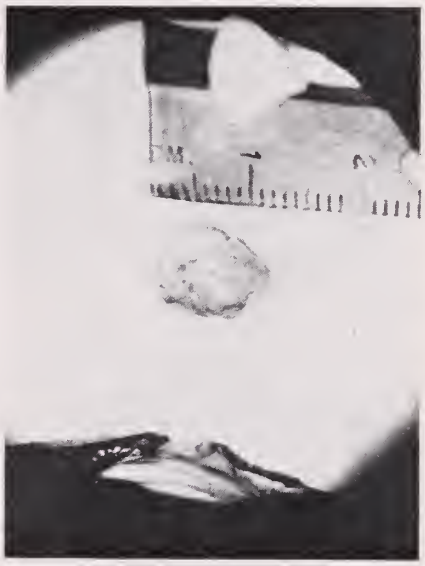

Figure 5—Smallest tumor recorded in the series, 1.2 cm.

Table 2—Patients with negative study

HISTORY	No. 7	No. 8	No. 9	No. 10	No. 11	No. 12	No. 13	No. 14
Age	44	52	32	62	42	69	65	62
Sex	Male	Female	Female	Male	Male	Female	Female	Female
VIII Loss	2 yr.			5 yr.		2 mo.	6 mo.	2 mo.
Tinnitus	+			Bilat.	+	+		+
Unsteadiness			+		+		+	
AUDIOLOGY								
Speech Discrimination	N	N	N	↓R	↓L	Severe L	↓R	↓R
SISSI	N	N	N	Low	+	+	+	+
Tone Decay	None	None	None	None	None	None	None	+R
Sensory-Neural	H. Freq. R	N	H. Freq. R	Bilat. R>L	↓L	Bilat. L>R	↓R	↓R
Stap Reflex Decay	NT	↓L	NT	+R	N	NT	+R	+R
ENG	Direct R	N	Weak R	N	Weak L	+	N	R
RADIOLOGY								
Tomograms	2 mm R	2 mm L	2 mm R	Flare R	2.5 mm L	N	4 mm R	N
CAT	+R	+L	+R	N	N	Not done	N	Not done
Pantopaque	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.	Neg.

patients tested. The ENG was positive on three of five tested, demonstrating canal paresis. Plain x-ray films suggested canal asymmetries in each case. The computerized axial tomogram, although read as abnormal in two of six small tumors, was equivocal. Pantopaque myelography demonstrated the tumor in each case. The cerebrospinal fluid protein was abnormal in only one of the six cases and that patient had had two previous pantopaque myelograms. All tumors were in the range of 1-2 cm (Fig 5).

The eight patients evaluated with normal pantopaque studies (Table 2) demonstrated decreased pure tone audiometry in seven of eight evaluations. Speech discrimination was abnormal in five. Four of eight patients had abnormal reflex decay. One patient demonstrated tone decay. Three patients had patterns consistent with cochlear involvement and had positive Metz test. Electronystagmography lateralized to the affected ear in four patients. X-ray films were abnormal in six patients. The CAT scan was abnormal in two of seven patients. The two patients with positive scans did not have the audiometric criteria and had only minimal clinical findings. However, because of a positive scan, even though equivocal, they were investigated by a pantopaque study.

In our experience patients with acoustic schwannomas had a unilateral asymmetrical hearing loss, a disproportionate decrease in speech discrimination, tinnitus, changes in the appearance of the internal auditory canal, and a longer course. The ages ranged between 38 and 65; however, five of the patients were between 38 and 54.

Of our eight acoustic neuromas seen in the last year, six were smaller than 2 cm. All had anatomical saving of the facial nerve. Two had no dysfunction whatsoever after surgery. One had partial loss which recovered two weeks postoperatively and three had total loss of facial function. However, the latter had partial return and we expect progressively full return of function. In our last case which represented the smallest tumor, we have been able to save facial, hearing, and vestibular function (Fig 5).

Conclusion

Thorough investigation of patients with unilateral hearing loss and ipsalateral radiological evidence, either by plain or tomographic studies, has yielded a greater percentage of acoustic tumors than expected from a local population. The possibility of preserving hearing and facial functions was the most important indication for initiating the evaluation of the small acoustic schwannoma. The rate of growth for these neoplasms is unknown. However, in some cases a few months may be the difference between preserving hearing or completely losing this capability. We advocate surgery when the lesion is detected in order to decrease morbidity and mortality to negligible levels.

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Ongoing program of outpatient sterilizations

Robert E Hassler, MD, Monroe, Wisconsin

TUBAL COAGULATION by laparoscopy as a means of sterilization has most readily been accepted as a hospital procedure with the patient under general anesthesia. With the advent of the outpatient surgical center and a reduction in surgical complications such as hemorrhage, infection, and injury to adjacent tissues, there has been an increase in outpatient laparoscopy with many economical and social advantages, without patient compromise.[1,2,3,4] The outpatient approach has been particularly useful in areas where hospital facilities have either been inadequate or highly restricted. The advantages to the patient in terms of convenience, efficiency, and cost are obvious; and because the complications have been very few and minor, I will report to the medical community what appear, at least to me, to be advantages of an ongoing outpatient sterilization program.[4-5]

Selection of patients

Since tubal coagulation must be regarded as an irreversible procedure, the patients who request it, and those to whom it is recommended, must be very carefully screened. It is imperative that both the patient and her husband understand the procedure completely, its consequences and its risks, before they sign the permission form. Before meeting me on a consultation basis for the requested procedure, the patient and husband, in the waiting room, will have read a complete brochure on the subject, detailing the procedure and all possible complications. After the examination, the complications are reiterated. If there are no questions and if this is acceptable to the patient and her husband, the patient is then scheduled for the sterilization procedure. The husband's signature is required and this applies as well to separated individuals. Divorced and single women do not require an additional signature.

In our series of 600 patients, 6% have been done for medical reasons and 17% had undergone previous lower abdominal surgery. The age range has been from 20 to 49 years, with no patient under the age of 20. Initially, most of the patients were between the ages of 30 and 39, with the second highest age group between 40 and 49 years. Now, the second highest group is between the ages of 20 and 29.

Preparation of patients

We insist upon a seven-day waiting period between the decision to operate and the procedure itself. Then the patient is required to undergo a complete medical examination, just as if she were having the procedure carried out in a hospital. Routine preoperative surgical care is strictly enforced.

The patients receive, intravenously and slowly, diazepam (Valium®) (the dose has varied from 15 to 50 mg) and meperidine (Demerol®) 100 mg. Enough medicine is given to the patient to provide sleep. Approximately one-half of the patients have required an oral airway, but no intubation or other resuscitative procedure. The patient's respiratory effort is greatly enhanced with the CO_2 insufflation of the abdomen, and there is also a measure of respiratory stimulation from the use of the local infiltration periumbilically. Along with the analgesia of Valium® and Demerol®, a local anesthetic is administered using 1% lidocaine (Xylocaine®). After the patient is sedated, she is placed in the dorsal lithotomy position. The cervix is cleaned with Betadine® and a cervical apparatus is applied so that the corpus, if necessary, can be manipulated by the nurse in attendance. However, this is rarely necessary. The patient is then replaced on the operating room table in supine position, soft restraints applied to the upper and lower extremities, the coagulating apparatus is grounded adequately, and the skin is prepped with Betadine® and draped under routine sterile conditions.

Results and discussion

Initially, in the first 10 patients, not only was a bilateral tubal coagulation performed but also a segment of each fallopian tube was excised. The distal and proximal ends of the fallopian tube were cauterized, and the specimen submitted for pathological verification. After evaluation of the first 10 cases, it was decided that the excision of a segment of the fallopian tube was not necessary and probably enhanced the possibility of complications; and pathological verification was only an additional cost to the patient.

After a three-month interval, two of the patients were reevaluated by hysterosalpingography (one at the request of the patient, the other by the physician). Of the two hysterosalpingograms performed, complete occlusion on one side was demonstrated, but under pressure there was some leakage of dye from the proximal segment of the other side. No further procedure was done in one patient but the other patient was redone under local anesthesia and analgesia on an outpatient basis.

Since the first 10 sterilization procedures, only bilateral tubal coagulation has been performed; and there has been no further evaluation by any other diagnostic procedure. One patient who had the procedure performed twice gave

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us the opportunity to observe the healing progress with a "second look." We noted that after a two-month interval the healing was incomplete. The tissues appeared to resemble an unresolved third-degree burn.

The complications that have been experienced to date are listed below: there were only six minor complications among the 600 patients. Preperitoneal carbon dioxide developed in four patients. However, the procedure was completed without incident in three of the four patients. One patient had the procedure terminated because reentry into the peritoneal cavity was not possible. There has been one anterior fundal perforation. This area was cauterized, observed, and, with no further bleeding, no other procedure was necessary. After one week, a second-degree burn was noted on the calf of the right leg of another patient and this was attributed to the patient's restlessness and our failure to use soft restraints for the first several patients.

There now have been over 600 surgical procedures performed, and for every procedure started there has been a completion; *ie,* no failures. However, in one patient, because of omental and filmy adnexal adhesions, with a retroverted retroflexed corpus, there was a failure in providing adequate cautery of the left fallopian tube.

At no time has there been any patient with respiratory compromise with the use of intravenous Demerol® and Valium.® The oral airway is used 50% of the time because of muscular relaxation. There has been no significant alteration in the blood pressure or pulse rate.

Bleeding, immediate or delayed, has not occurred; nor has there been a patient with intra-abdominal cautery burns or infection. There have been no problems noted during the postoperative examination (abdominal incision or pelvic examination).

Two patients, one month after the surgical procedure and after a menstrual period, developed pelvic discomfort and a low-grade temperature. The first patient was hospitalized and evaluated completely. All tests, including cultures, were negative. Recovery was accomplished after starting an anti-inflammatory agent plus antibiotics. This patient stated that the problem started after having sexual activity with her husband, who was very "rough." The second patient had many complaints including upper abdominal ones. However, because of the first patient and her response, antibiotics were utilized after all other tests were negative. The second patient was treated on an outpatient basis.

One patient was less than four weeks pregnant when the cautery was done and delivered at term, uneventfully, a healthy female without complications. This patient did not follow directions regarding the restarting of her oral contraceptives.

One ectopic pregnancy has occurred, two years after the tubal coagulation, which required a pelvic laparotomy. Examination of the clots removed from the pelvis demonstrated early placental villi. Fimbrial segments of both fallopian tubes were normal as were the ovaries and peritoneal surfaces. Subsequent hysterosalpingogram did not demonstrate any uterine defect.

As anticipated, there have been very few delayed problems for dysfunctional uterine bleeding, with only three dilatation and curettage procedures necessary. There have been four hysterectomies because of pelvic pain and recurrent dysfunctional uterine bleeding. There has been one hysterectomy for extensive endometriosis. The endometriosis was noted 18 months earlier at the time of the sterilization procedure, but it was minimal and as the patient was not on oral contraceptives, it was discussed with her in detail and no definitive therapy was indicated at that time.

Intrauterine devices (IUDs) are removed at the time of the procedure with no sequellae. One always has to suspect an occult endometritis with IUDs. The last patient with an IUD (October 1977) had had bilateral fimbrial occlusion with a history of an uneventful vaginal delivery in 1975, an IUD inserted post-partum, and some vague lower abdominal pain for two weeks in 1976, with a complete blood cell count, sedimentation rate, and pelvic examinations within normal limits at that time.

There has been no increase in dysmenorrhea.

There has been little need for "second looks" except for the one repeat procedure, the one ectopic pregnancy, and the hysterectomies. Of those examined, there was a complete disappearance of the inner half to two-thirds of each tube. The remaining fimbrial segment and mesosalpinx were entirely normal.

Patient acceptance and cooperation have been excellent. All patients are asked several questions including memory for the procedure; and if it were necessary, would they choose to do it over again in the same manner. All patients, except two, have answered in the affirmative. When patients have returned for their routine examinations, they are asked whether they have regretted the procedure. All have answered "no." There have been two requests for reversal, one of which was a remarriage.

Conclusions

Outpatient, nonhospital-based laparoscopic sterilizations are a safe, economical, practical approach to permanent sterilization. Over 600 patients and five and a half years of experience have lead to an affirmative enforcement of the above.

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Neonatal hypoglycemia

Robert Perelman, MD, Madison, Wisconsin

THE PROBLEM OF neonatal hypoglycemia has been associated primarily with infants of diabetic mothers. However, there are a significant number of other causes for hypoglycemia. The accompanying article outlines causes, symptoms, and management of this potentially hazardous problem.

SINCE THE FIRST description of eight patients by Cornblath[1] in 1959, hypoglycemia has become perhaps the most commonly diagnosed metabolic abnormality in the neonate. "Pathogenetically, idiopathic neonatal hypoglycemia can be regarded as a failure to adapt to independent extrauterine life."[2] "The multiple physiologic and biochemical changes that occur during this rapid period of adaptation reflect prenatal events, perinatal stresses, and the interaction of multiple hormones and substrates at and after birth."[3] Thus the general neonatal disorder termed hypoglycemia must be considered as having multiple etiologies.

Although the frequency of low blood glucose levels in neonates is highly variable and dependent upon the criteria for diagnosis, the population surveyed, and the methods for sample collection and analysis, the overall incidence is 4.4 per 1000 live births.[4] If infants at risk rather than the total population are emphasized, the percentage of neonates who manifest hypoglycemia rises sharply. Table 1 lists the most common neonatal conditions associated with a significantly increased likelihood of hypoglycemia.

Classical transient hypoglycemia as defined in Table 2 usually occurs within the first 72 hours of life; and although most often symptomatic (Table 3), may only be recognized by repeated glucose determinations prompted by a high index of suspicion for a neonate at risk.

Because hypoglycemia represents a multifaceted problem and is often associated with other neonatal disease states, no overall definitive prognostic data exist. Specific statements regarding morbidity and mortality at present depends upon severity, duration, and underlying etiology. Numerous reviewers have approached the controversy

Table 1—Neonates at risk for hypoglycemia

1. Small for gestational age
2. Prematures
3. Perinatal asphyxia
4. Cold stress
5. Infants of diabetic mothers
6. Erythroblastosis fetalis
7. Sepsis
8. Large for gestational age
9. Polycythemia
10. Maternal toxemia
11. Iatrogenic
    a. Abrupt discontinuation of intravenous glucose
    b. Post-exchange transfusion
    c. Discontinuation of hyperalimentation

Table 2—Definition of hypoglycemia during the first three days of life

1. Blood Glucose (true) $<$ 30 mg/100 ml in term infants
2. Blood Glucose (true) $<$ 20 mg/100 ml in premature infants
3. Blood Glucose (true) $<$ 40 mg/100 ml in any infant with compatible symptoms (especially tremors, convulsions, apnea, unexplained tachypnea or cyanosis)

or, simply

30 mg/100 ml for days 1, 2, 3
40 mg/100 ml for infants beyond 3 days of age

Table 3—Major presenting sign of hypoglycemia

1. "Jitteriness" (tremors)	36%
2. Unexplained cyanosis (usually with tachypnea: possibly cardiomegaly)	34%
3. Frank seizure	16%
4. Apnea	11%
5. Severe hypotonia	7%

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Publication support provided by the Wisconsin Perinatal Center, Southcentral Region, Madison.

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regarding outcome.[5-7] The results of a prospective study by Pildes et al[8] support the tenet that treated neonatal hypoglycemia does not always have a poor prognosis. "All agree that early recognition and effective therapy with the prevention of convulsions may well lead to a better outcome than previously reported. Certainly, prevention of hypoglycemia should be the ultimate goal."[9] A stepwise approach to therapy is outlined in Table 4.

Table 4—Stepwise approach to management

1. Monitor blood glucose in "at risk" infants by performing Dextrostix at the time of admission to the nursery and at 0.5, 1, 1.5, 2, 3, 4, 6 hours of age . . . and during treatment at regular intervals of about 1 hour.
2. For blood sugar < 30 mg/100 ml or < 40 mg/100 ml with symptoms, begin feedings early (1-4 hours old) using 3 ml/kg of D-10-W by gavage or nipple (if able to suck-swallow and if without tachypnea or central nervous system malfunction); follow this in 30 minutes with 3 ml/kg of 20 cal formula.
3. If above is unsuccessful after 1 hour (or with blood sugar < 20 mg/100 ml), start IV and give D-10-W as 3 ml/kg STAT and 3 ml/kg/hour constant infusion.

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Abstracts

Increased growth after long-term oral vitamin D_3 in childhood renal osteodystrophy

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N Engl J Med 298:238-242 (Feb 2) 1978

Oral 1,25-dihydroxyvitamin D_3 (1,25-$(OH)_2D_3$) was prospectively evaluated in an outpatient setting for as long as 26 months in six prepubescent children with uremia and renal osteodystrophy. Each was previously treated with vitamin D_2. Therapy was given a 14 to 41 pg/kg/day in order to correct hypocalcemia and reverse bone disease. Each patient had previously received vitamin D_2 and oral calcium, yet had bone disease and short stature. Four had radiologic findings of severe rickets and secondary hyperparathyroidism.

Mean serum creatinine rose by 49% during the study, but was similar to the rate of rise before the initiation of treatment. Serum levels of 1,25-$(OH)_2D_3$ were initially reduced at 15 ± 5 pg/ml (mean ± SEM) and after treatment rose to 54 ± 13 pg/ml. Serum calcium rose from 7.5 ± 1.6 mg/dl (mean ± SD) to 9.8 ± 0.6 after one month ($p < 0.02$). All 186 post-therapy calcium values were 9.9 ± 0.4 mg/dl. Serum phosphorus rose from 5.6 ± 2.6 to 7.2 ± 2.8 after four months of therapy (not significant), and alkaline phosphatase activity fell from 536 ± 298 to 208 ± 91 IU/L after 12 months ($p < 0.05$). Serum immunoreactive parathyroid hormone levels fell from 900 ± 562 μ/Eq/ml to 411 ± 377.

Healing of rickets and subperiosteal erosions occurred in each. Remineralization of bone was demonstrated by the photon absorption technique. Subjective improvement in muscle strength and gait was noted in five patients. In four patients height velocity, evaluated for 12 months pre- and post-therapy, increased from 2.6 ± 0.8 to 8.0 ± 3.2 cm/year ($p < 0.05$). Height velocity/year increased from <3 percentile in each to the 10 to 97 percentile after therapy. Height increment ranged from 27 to 113% of that expected for change in chronologic age, and 40 to 114% expected in bone age after therapy. Mild side effects included mild hypercalcemia in younger patients and hyperphosphatemia, possibly related to reduced parathyroid hormone levels.

This trial showed that oral 1,25-$(OH)_2D_3$ can reverse renal bone disease and increase height velocity in uremic children. ■

Scientific Medicine

Severe preeclampsia presenting as hepatobiliary disease

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• Hepatobiliary dysfunction occurs in severe preeclampsia. Three patients who had severe preeclampsia were referred misdiagnosed as hepatobiliary disease. All three patients had hypertension, abnormal liver function test, and thrombocytopenia, associated with abdominal pain associated with either nausea or vomiting. Although originally misdiagnosed as acute cholecystitis or viral hepatitis, the correct diagnosis was subsequently made, and all three patients and their children did well following delivery. When abnormal liver function tests in the third trimester of pregnancy suggest hepatobiliary dysfunction, severe preeclampsia should be considered in the differential diagnosis. Further evaluation may be necessary to confirm the diagnosis.

ALTHOUGH hepatobiliary dysfunction occurs in severe preeclampsia,[1,2,3] many clinicians are not aware of the clinical presentation or the laboratory abnormalities associated with this disorder. As a result, in the last 18 months, three patients who had severe preeclampsia were referred to us mistakenly diagnosed as hepatobiliary disease.

Case reports

Case 1. A 22-year-old gravida 1, para 0, white woman developed right upper quadrant pain and vomiting at 35 weeks gestation. Examination revealed an SGOT of 459 IU, an alkaline phosphatase of 100 IU, an SGPT of 235 IU, an LDH of 756 IU, and a bilirubin of 5.5 mg per dl. She was felt to have viral hepatitis, and she was treated with intravenous fluids and nasogastric suction for five days. Her blood pressure during this period was in the range of 150-180/100-120 mm Hg and she had 2-4+ proteinuria. She required four units of packed cells because of a falling hematocrit; and when she was found to have a platelet count of 18,000 per cu mm, she was referred with a diagnosis of viral hepatitis, hemolytic anemia, and thrombocytopenia of uncertain etiology.

On admission she was felt to have severe preeclampsia with hepatobiliary dysfunction and platelet consumption. After a brief attempt to improve her hypertension and thrombocytopenia with intravenous sodium nitroprusside in the Intensive Care Unit, she was induced and delivered a normal boy weighing 1.6 Kg (3½ lb) who did well. Within five days postpartum all of her laboratory and clinical abnormalities returned to normal.

Case 2. A 26-year-old gravida 1, para 0, woman at 33 weeks gestation was admitted because of worsening of chronic hypertension in the range of 150-170/100-118 mm Hg with the development of 2+ pitting edema without proteinuria. The admitting diagnosis by the obstetrician was preeclampsia. Because of burning epigastric discomfort and right upper quadrant tenderness and a total bilirubin of 1.3 mg per dl, an alkaline phosphatase of 213 IU, an LDH of 350 IU, and an SGOT of 154 IU, an internist felt she had acute cholecystitis. She was found to have a platelet count of 39,000 per cu mm. The following day a Cesarean section was performed and a normal baby boy weighing 2 Kg (4 lb 13 oz) was delivered. At operation the hepatobiliary system appeared normal. Five days later the patient was discharged feeling well with a platelet count of 147,000 per cu mm, and improving liver function studies.

Case 3. A 32-year-old gravida 3, para 2, white woman at 34 weeks gestation was admitted because of mid-epigastric abdominal pain with nausea but no vomiting. She was found to have an SGOT of 152 IU, an LDH of 345 IU, a bilirubin of 0.7 mg per dl, and an alkaline phosphatase of 71 IU. The admitting diagnosis was acute cholecystitis and she was treated with nasogastric suction and analgesics. She was found to have a platelet count of 32,000 per cu mm and a blood pressure of 140/100 mm Hg with 2+ proteinuria, and was felt to have preeclampsia with platelet consumption and hepatobiliary dysfunction. After a brief trial of heparin failed to improve her platelet count, a Cesarean

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section was performed at which time a placenta accreta was found and a hysterectomy done. The baby did well. Her liver function deteriorated over the next 24 hours and then rapidly improved. At discharge one week later the platelet count was 161,000 per cu mm and her liver function was almost normal.

Discussion

Clinicians frequently see patients with hepatobiliary disease and not preeclampsia. They may be misled by the clinical and laboratory features illustrated in the above cases. Right upper quadrant and/or epigastric pain, nausea, vomiting, and jaundice, may suggest acute cholecystitis and/or cholelithiasis, peptic ulcer disease, pancreatitis, or hepatitis. Routine laboratory tests may show elevated transaminases, alkaline phosphatase, bilirubin, and anemia. In the third trimester of pregnancy, when these symptoms and signs develop, preeclampsia should be considered in the differential diagnosis.[4] Attention should be focused on the presence or absence of hypertension and proteinuria. Abnormal liver function tests in this syndrome may suggest either hepatocellular or obstructive liver disease. A careful examination of the peripheral smear for schizocytes and a platelet count should be done.[5] If the diagnosis has not been established, further helpful information may be obtained by a complete coagulation profile, and evidence of intravascular hemolysis may be obtained by finding a decreased haptoglobin level, an increased plasma hemoglobin level, and hemoglobinuria or hemosiderinuria.[5]

Physicians evaluating patients in the third trimester of pregnancy who appear to have evidence of hepatobiliary dysfunction should suspect the diagnosis of severe preeclampsia, and consider all the clinical as well as laboratory signs indicative of this disorder.

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Abstracts

Occupational asthma due to tetrachlorophthalic anhydride

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J Occup Med 20:183-188 (Mar) 1978

The plastics industry uses a number of organic chemicals which have the potential of producing pulmonary reactions, particularly in susceptible persons. Five workers who were involved in the production of epoxy resins had recurrent respiratory symptoms and physiologic abnormalities following exposure to tetrachlorophthalic anhydride (TCPA). Inhalation challenge with TCPA reproduced their symptoms and there was both an immediate and late (4 to 6 hours) physiologic response. Although the clinical picture strongly suggested a hypersensitivity reaction, immunologic studies failed to show precipitating or specific IgE antibody. Avoidance of exposure resulted in resolution of symptoms; however, three of the five workers had residual functional impairment. ■

Progressive chorioretinopathy after receiving thioridazine

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Arch Ophthalmol 96:1172-1176 (July) 1978

A distinctive appearance of the ocular fundus as a late complication of high doses of orally administered thioridazine hydrochloride (Mellaril®) is described. Discrete nummular areas of loss of retinal pigment epithelium (RPE) extended from the posterior pole to the midperiphery. Fluorescein angiography demonstrated loss of choriocapillaris in these zones. Atrophy of the remaining RPE was progressive, with advancement of the edges of the atrophic zones and breakdown of bridges of RPE separating them. Atrophy occurred after discontinuation of the drug and advanced without further exposure to it. Dark adaptation, the electroretinogram, and the electrooculogram were abnormal in the late stages. Central visual acuity remained relatively good. ■

Treatment of tumors of the brain*

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In his recently published autobiography, the late Wilder Penfield describes his early operative experience in New York prior to moving to Montreal.[1] During a memorable week, he performed long arduous craniotomies for tumor on three patients with three prompt postoperative deaths. In the subsequent five decades, neurosurgical capabilities have improved sufficiently so that death or major morbidity following craniotomy is a relatively rare event. Obviously, today's surgeons do not surpass Penfield in skill or dedication. The improvement is the result of much more effective tools, techniques and medications, both for the neurosurgeon and for his colleagues in neuroradiology, neuroanesthesia, radiation therapy, and neurological nursing.

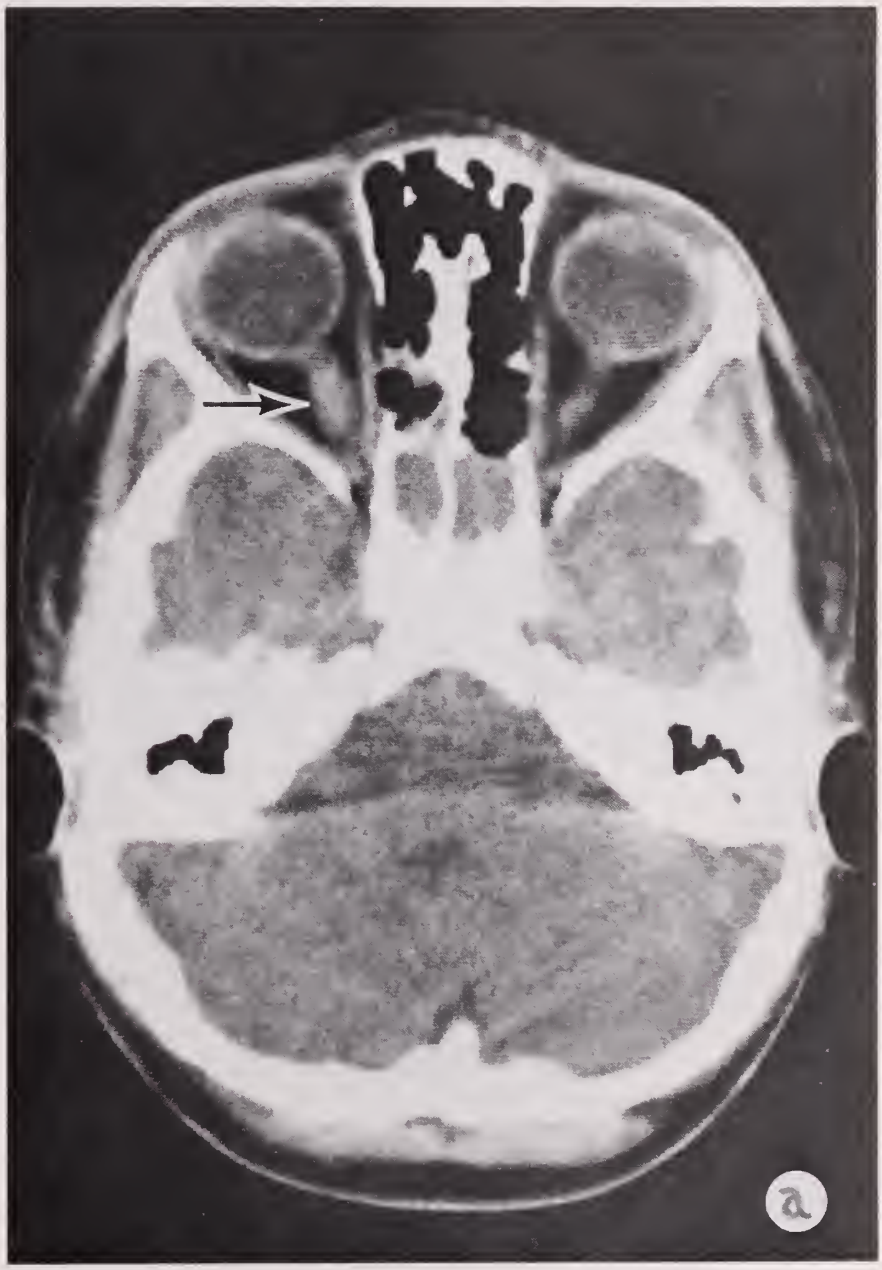
The diagnostic studies of patients with brain tumors with specialized cerebral angiography and second generation CT (computerized tomographic) scanning (often supplemented with multi-directional tomography and radionucleide scanning) provides the surgeon with a detailed map of the spatial and vascular characteristics of the tumor and occasionally an accurate prediction of the histology. Thus, the surgeon can accurately focus his efforts, via the least traumatic route, on the tumor mass, whether located on the surface or deep within the brain. The need for blind cortical biopsies has been eliminated.

In the following two cases recently developed neuroradiological techniques were crucial for successful management.

Case reports

Case 1. An adolescent schoolgirl had complained of difficulty reading, but only in school, for the past eight months. A complete neuro-ophthalmological evaluation was normal ex-

Figure 1a—Optic glioma (arrow) in an 11-year-old girl.



*Portions of this manuscript will appear in *Current Therapy, 1979,* W B Saunders Company Publishers.

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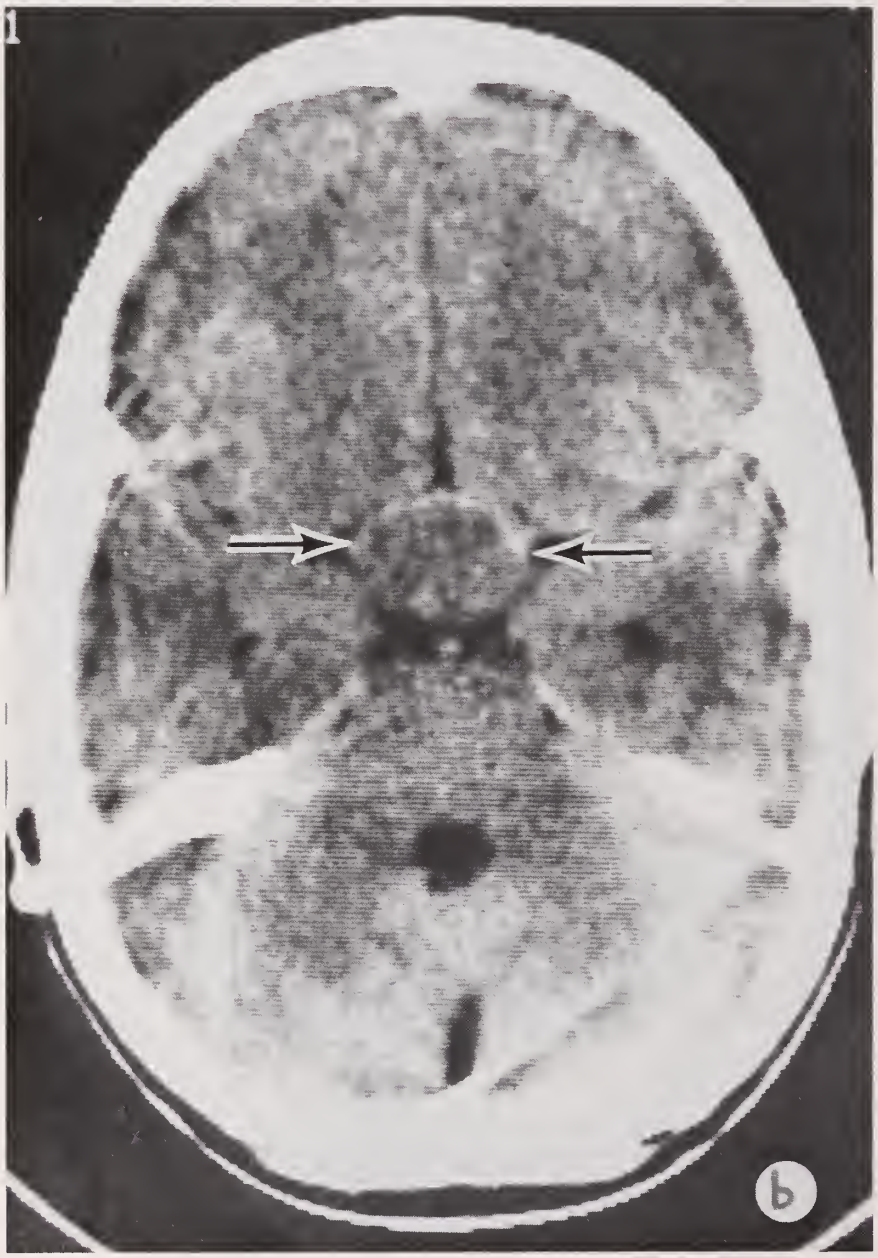
cept for very slight diminution of visual acuity in the right eye and a diagnosis of conversion reaction was considered. Following this computerized tomogram a diagnosis of optic glioma (Fig 1a, arrow) with extension into the chiasm (Fig 1b, between arrows) was made. She was given radiation therapy and recovered normal visual function.

Case 2. A middle-aged electrician had complained of diplopia and tic-like facial pain for several years. Examination showed impairment of left 3rd, 5th, and 6th cranial nerve functions and the patient was diagnosed as having multiple sclerosis after a normal carotid angiogram and radionucleide brain scan at a local hospital. Figure 2 is an inclined lateral, coned, and magnified (×3) view of the left internal carotid circulation after processing to reduce bone shadows (subtraction). The vascular tumor (arrow heads) is fed by the meningohypophyseal trunk (arrow) of the internal carotid artery. The tissue diagnosis following excision was benign meningioma. He had partial recovery of his preoperative cranial nerve impairments.

Figure 1b—Optic glioma with extension into the chiasm (between arrows) in an 11-year-old girl.



Nonoperative methods of treatment

(a) Treatment with synthetic steroids often provides many weeks or months of comfortable life. One must accept, and if necessary, prepare the patient for the discomfort of hypercorticolism, but this should not deter the use of steroids when necessary for control of tumor morbidity. The dose must be titrated against the patient's signs and symptoms and may vary from 0.5 mg to 100 mg per day of dexamethasone or its equivalent. The steroid is given in divided doses three or four times daily accompanied by antacid therapy between meals and at bedtime.

(b) The use of osmotic diuretics can be lifesaving and may provide time for diagnosis and elective surgery. Their use may be indicated both in the hospital during acute exacerbations of intracranial hypertension (mannitol 0.25 to 1.0 g/kg IV q 3 to 6 hours) or more chronically (glyceryl 0.8 to 1.2 cc/kg p.o. q 4 to 8 hours). Some means of intracranial pressure measurement may aid materially in guiding steroid and osmotic therapy both acutely and chronically.

(c) The ability to safely and accurately follow tumor size with CT scans has encouraged neurosurgeons to observe the biologic behavior of small benign tumors in the elderly. Occasionally such patients with very indolent lesions can be spared the necessity for craniotomy.

(d) In treating patients with incurable tumors, it is most important that the patient does not feel a sense of abandonment as he is referred to a series of specialists, usually ending with the chemotherapist or nursing home staff. The need for additional consultation should be explained and the patient reassured that he has continuing access to all members of the treatment team. The patient should be reassured that regardless of what problem the tumor may present, some member of the team will be able to help in some way.

Hospital capabilities

(a) It is the authors' opinion that brain tumor treatment should occur in a hospital having sufficient num-

Figure 2—Angiogram of a meningioma arising from the dura over Meckel's cave in a 39-year-old man.

bers of neurosurgical patients to allow the development of specialized neurosurgical nursing care. Such a unit ideally has an intensive care area with patient monitoring capabilities. This does materially increase the chance for morbidity-free surgical treatment. The nonphysician staff must be trained in both neurological diagnostic techniques and the use of monitoring instrumentation. The training must be followed by a sufficient case load to maintain staff skills.

(b) Another crucial hospital capability is immediate access to a CT scanner, staffed 24 hours a day and located in close proximity to the postoperative ward. The scanner can be lifesaving in diagnosing and localizing postoperative hematomas which are not necessarily at the site of tumor resection.

Operative considerations

(a) It is important to begin daily bacteriostatic shampoos as soon as craniotomy is scheduled. Prophylactic intravenous antibiotics (*eg,* nafcillin 1 gm q 4 hours) begun just before surgery are recommended in cases with increased risk of infection such as those involving a shunt for cerebrospinal fluid.

(b) Coordination with a neuroanesthesiologist is crucial especially when special techniques such as intraoperative hypotension or recording of cortical evoked responses are required.

(c) With markedly vascular lesions, the immediate preoperative embolization of major feeding arteries, usually by a neuroradiologist using catheter techniques, may be crucial to the success of an operation.

(d) In the author's opinion, elective craniotomies should be done in operating rooms equipped to handle the full gamut of complicated neurosurgery. Included are an operative microscope and microneurosurgical instruments including those required for vascular lesions. Instrumentation for constant monitoring of blood pressure and blood gases as well as monitoring for air embolism is essential.

(e) Intraoperative recording of cortical evoked potentials can be crucial for preservation of neurological function, particularly with lesions of the brain-stem and with those involving the primary visual pathways.

Craniotomy

Details of operative techniques are not relevant, but Table 1 is a broad summary of what the neurosurgeon can expect to accomplish with individual tumors. The general principle of obtaining a tissue diagnosis, if at all possible, is followed in almost every case. This principle also applies to such lesions as pineal area tumors since the risk of exposure of deep basal and midline tumors is now markedly reduced. Thus, the patient with a rare benign tumor in these less readily accessible areas may be spared the potential morbidity of radiation therapy. The senior author does not practice "biopsy only" technique with malignant gliomas since tumor debulking and internal decompression are felt to be important to achieve maximum benefit from radiation and chemotherapy.

Anterior basal routes of exposure may be required for successful treatment of lesions expanding the sella turcica or eroding the clivus; transsphenoidal and transpharyngeal approaches are used, respectively. The lateral cervical approach to the clivus has little if any application.

A precraniotomy cerebrospinal fluid shunt may markedly improve the operative results in patients deteriorated from hydrocephalus. This commonly occurs with posterior fossa tumors such as medulloblastomas.

Continuing neurosurgical follow-up should be provided for all brain tumor patients with routine performance of repeat CT scanning at appropriate intervals and whenever there is an abrupt change in the

neurological condition. Occasionally a change in the biologic behavior of the tumor such as development of a cyst or localized tumor mass may dictate the need for craniotomy late in the course of an incurable tumor. This is more likely to occur in tumors treated by radiation therapy without prior craniotomy, *ie,* optic gliomas, and brain stem gliomas.

Radiation therapy

(a) *General considerations*—Irradiation is utilized in the management of many, if not most, patients with brain tumors. The indications for radiation therapy and the techniques of treatment depend upon the patient's age and functional status, the tumor location and histology, and the surgical resectability. Successful treatment depends upon understanding the natural history of brain tumors with maximal exploitation of the differential responsiveness to irradiation of normal brain tissue and neoplastic tissue. In many instances, radiation therapy can be shown to improve neurological function, prolong survival, and improve the quality of survival.

Modern radiotherapy employs megavoltage equipment and localization techniques which permit relatively high doses of radiation to precisely defined volumes. CT scanning increases the accuracy and safety of such treatment by enhancing our knowledge of tumor behavior and the precision of field definition. While wide-field irradiation of the entire cranium or the entire neuraxis (brain and spinal cord) is indicated for many patients with central nervous system neoplasms, limiting the volume of irradiation to localized, relatively noninvasive tumors is a distinct advantage.

With the exception of the peculiarly radiosensitive pineal germinomas, irradiation of most primary brain tumors requires doses approaching the tolerance of normal brain. Treatment fractionation with low daily doses (150 - 180 rad), total doses below 5500 rad in six to eight weeks, and reduction of field size when feasible minimize the occurrence of post-irradiation complications. One must balance the potential benefits of treatment against the risks of damage to normal brain structures.

(b) *Normal tissue reactions*—During treatment one may occasionally see nausea, appetite suppression, or lassitude; however, most patients experience no immediate reaction except alopecia and cutaneous erythema. With megavoltage irradiation, patients will usually have regrowth of hair within six months.

An important and poorly understood reaction to radiation therapy is the development of headache, lassitude, low grade fever, or enhanced local neurologic symptoms and signs, four to eight weeks after the completion of treatment. This syndrome has been attributed to a transient, partial demyelinization

Table 1

BRAIN TUMOR	SURGERY		RADIATION THERAPY			CHEMOTHERAPY		RANGE OF MALIGNANCY	AGE PREDILECTION		LOCATION PREDILECTION		
	Pallia-tive	*Cura-tive*	*Local*	*Total Brain*	*Total CNS*	*Sys-temic*	*Intra-thecal*	*0-4*	*Older*	*Younger*	*Tentorium Above*	*Tentorium Below*	*Other Specific*
Malignant glioma (grades III-IV) (glioblastoma)	+	−	−	+	±	+	−	3-4	+	−	+	±	−
Glioma grade I-II	+	±	±	±	−	−	−	1-2	−	+	±	+	−
Meningioma	±	+	±	−	−	−	−	0-2	+	−	±	±	−
Metastatic	±	−	±	+	−	±	−	2-4	+	−	+	±	−
Oligodendro gliomas	+	−	+	±	−	±	−	2-3	+	−	+	−	−
Schwanomas (Neurinomas)	±	+	±	−	−	−	−	0-1	+	−	−	+	+
Pituitary adenomas	±	+	+	−	−	−	−	0-1	+	−	+	−	+
Cranio-pharyngioma	±	±	+	−	−	−	−	0	−	+	+	−	+
Medullo-blastoma	±	−	−	−	+	+	+	4	−	+	−	+	−
Ependymoma	+	±	+	−	±	±	±	1-4	±	±	±	±	−
Hemangioblastoma	±	+	±	−	−	±	−	0-3	+	−	±	+	−
Pinealoma	±	−	±	+	±	+	±	1-4	±	+	−	−	+
Optic glioma	±	±	+	±	−	±	−	0-3	−	+	−	−	+
Brain stem glioma (Pontine glioma)	±	−	+	−	−	±	−	1-4	−	+	−	−	+

Key: + yes or usually; − no or never (almost never); ± maybe or occasionally

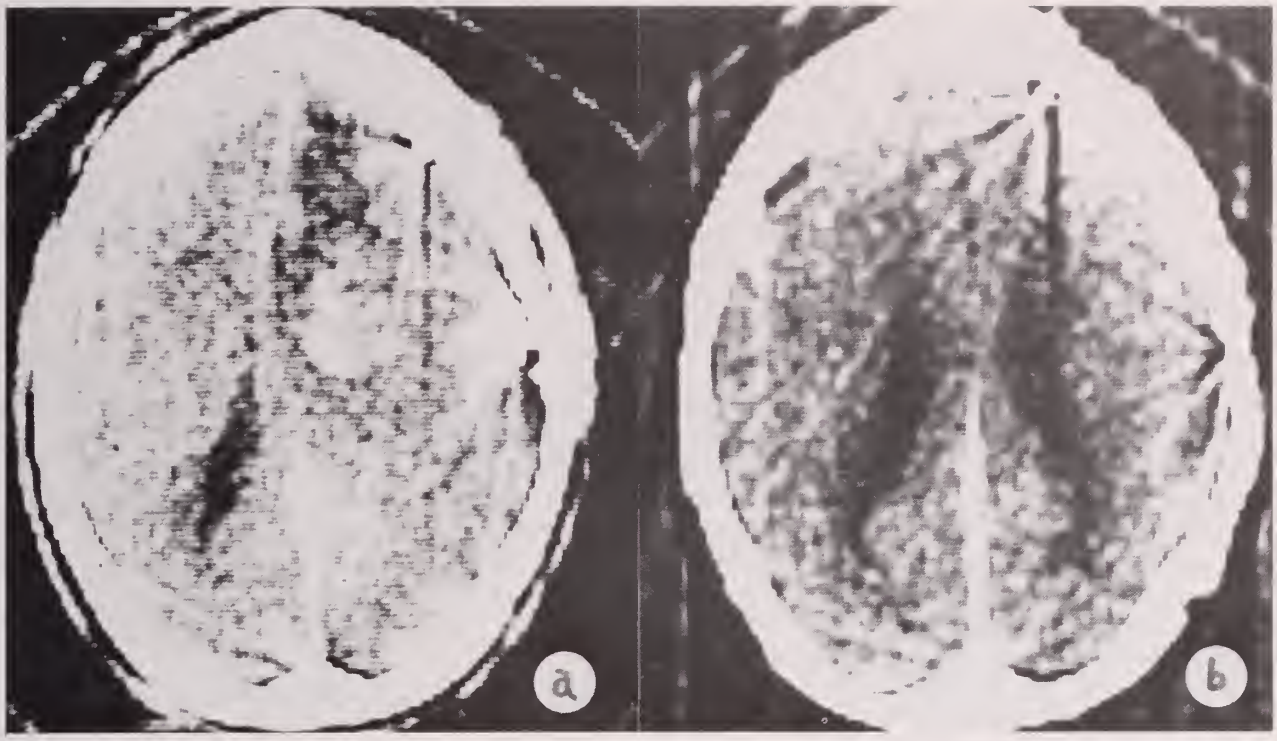


Figure 3—CT scan of a 15-year-old male with a grade III glioma (a) before and (b) after postoperative chemotherapy.

within the treated volume. Symptoms and signs are diminished by corticosteroids, with spontaneous resolution in 5 to 30 days. Knowledge of this is particularly important since it mimics tumor progression.

Late complications months to years following irradiation are fortunately rare, but instances of brain necrosis and major vascular occlusion have been reported. In most cases, these relate to excessive doses (rarely seen below 7000 rad), rapid treatment regimens, repeat courses of irradiation, or field techniques allowing excessive inhomogeneity.

Treatment of specific tumors

(a) *Malignant gliomas*—Postoperative irradiation improves both the quality and length of survival in patients with Grade IV lesions. In addition, a small number of patients with Grade III lesions achieve disease-free survival in excess of five years.

(b) *Metastatic tumors*—Cranial irradiation provides effective palliation for patients with metastatic brain tumors. Most patients experience significant improvement in neurologic symptoms following treatment, although long-term, disease-free survival in any patient with documented brain metastasis is rare. Rapid fractionation schemes (300 - 3600 rad in 2 to 2.5 weeks) have been well tolerated and effective in this group of patients where median survival following documentation of metastasis is measured in months.

(c) *Pituitary adenomas*—Small-field sellar irradiation is indicated in the primary or postoperative management of many patients with pituitary neoplasms. Significant suprasellar extension reduces the likelihood of irradiation control, and large or rapidly developing visual field defects are indications for more prompt decompression via a neurosurgical approach usually followed by postoperative irradiation. Reduction of tumor size and hormonal production (*eg,* growth hormone in eosinophilic adenomas) is gradual following irradiation, with favorable changes usually demonstrable over several months to a few years post-treatment. The transsphenoidal surgical approach to small functioning adenomas is an alternative, and usually preferred, form of initial therapy and may be curative, although there is need for longer followup with this relatively new treatment modality.

(d) *Medulloblastoma* — Medulloblastoma is a moderately radiosensitive lesion which can be cured in approximately 50 percent of the cases radically treated to the entire neuraxis (craniospinal irradiation). Such techniques are laborious and require exquisite immobilization and attention to treatment details, but result in a gratifyingly long, disease-free survival without serious treatment-related sequelae.

(e) *Other tumors*—Local radiation is often used with incompletely resected low grade gliomas, meningiomas, and craniopharyngiomas. Localized treatment without prior surgery is also commonly given to pinealomas, optic gliomas, and brain-stem gliomas. The treatment decision in such lesions requires multidisciplinary input.

Chemotherapy

Chemotherapeutic agents have demonstrated effectiveness in certain brain neoplasms. Transient responses of up to several months or a few years are reported in malignant gliomas, brain-stem neoplasms, medulloblastomas, and ependymomas. The adjunctive use of antineoplastic agents with surgery, with or without irradiation, has marginally improved survival time in patients with malignant gliomas. Tumor-free survival of significant duration, however, has been only infrequently noted following the use of such agents.

Most responses have occurred with the use of nitroureas (BCNU, CCNU, MeCCNU), procarbazine, high dose methotrexate, and vincristine. Sporadic responses have been noted with alkylating agents (cyclophosphamide, thiotepa), imidazole carboxamides (DTIC), and the newer epipodophyllotoxin (VM-26). The blood-brain barrier is usually defective within the center of the tumor mass, allowing good drug transport into the tumor; however, normal vessels retarding drug transport across this pharmacologic barrier exist at the periphery of the tumor where infiltrative growth is present. Indeed, most responses in malignant gliomas and brain-stem neoplasms have been limited to the lipid soluble nitroureas and procarbazine which have greater capability to pass through the normal blood-brain barrier. Some medulloblastomas respond markedly but transiently to the addition of vincristine, cyclophosphamide, and methotrexate. Systemic combination chemotherapy has yet to increase either disease-free or total survival time with medulloblastomas. Very occasionally an unexpectedly good result can be achieved (Fig 3).

A 15-year-old boy was treated by the authors beginning with craniotomy for tumor debulking of a Grade III glioma on Oct 19, 1976, followed by completion of 6,000 rad whole brain radiation on Dec 29, 1976 and CCNU—procarbazine therapy beginning Feb 3, 1977. Only traces of the contrast-enhanced tumor shown in Figure 3a were present at followup on Feb 7, 1978 (Fig 3b).

The paper provides guidelines only. For further neurosurgical details concerning specific tumors, the reader is referred to Youmans.[2] For further information concerning radiation therapy see Bouchard.[3]

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Abstracts

Burn unit management of toxic epidermal necrolysis

Robert H Demling, MD; Suellyn Ellerbe, RN; and Nicholas J Lowe, MB, MRCP, University of Wisconsin Hospitals, Madison, Wis:

Arch Surg 113:758-759 (June) 1978

Toxic epidermal necrolysis is the name given to a group of dermatologic disorders characterized by a separation of epidermis and dermis with a subsequent skin slough. The denuded areas have the appearance of a second-degree burn. The complications of infection, negative nitrogen balance, severe pain, and emotional instability are identical to those seen in patients with major burns. There are difficulties in patient management and advantages in burn unit care. Care of the patient with skin loss from toxic epidermal necrolysis is extremely complex, requiring the expertise of a burn team with that of the dermatologist. ■

Late results of atrial septal defect repair in adults

Donald J Magilligan, Jr, MD: Conrad R Lam, MD: Joseph W Lewis, Jr, MD, Henry Ford Hospital, Detroit, Mich; and Julio C Davila, MD, A Ward Ford Memorial Institute, Wausau Hospital North, Wausau, Wis:

Arch Surg 113:1245-1247, 1978

Repair of secundum atrial septal defects in 75 patients older than age 40 years was associated with a good long-term result, from five to 21 years postoperatively, in 89% of patients who were class I and II preoperatively and in 86% of those in normal sinus rhythm preoperatively. Functional class III or IV, atrial fibrillation, a higher pulmonary artery mean pressure and higher pulmonary vascular resistance affected the prognosis adversely. Repair of atrial septal defect in adults did not reverse existing atrial fibrillation and did not protect against the onset of new atrial fibrillation. ■

STATE MEDICAL SOCIETY OF WISCONSIN
WISCONSIN MEDICAL JOURNAL
1903 · 1978 75th ANNIVERSARY YEAR

USPS 688-360
Owned and published by the State Medical Society of Wisconsin
Journal Established 1903

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VOLUME 77

JANUARY 1978—DECEMBER 1978

A Monthly Journal of Medicine and Surgery

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State Medical Society of Wisconsin

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Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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- ☐ Proven antianxiety performance
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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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